**Community Dietetics Referral Form**

**This form can only be completed by a healthcare professional. If you are a parent/carer please contact the child’s GP to make the referral on your behalf.**

**Please complete ALL sections of the form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NHS Number (1 digit per box please)**   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  | | | **Date of referral** | | |
| **Patient name:**  **Patient address:**  **Patient contact number:**  Home:  Mobile: | | **Referrer name and job title:**  **Referrer address for correspondence:**  **Referrer contact number:** | | |
| **Date of Birth:** | | **Ethnicity:** | | |
| **GP name and surgery name:** | | **Reason for Referral:** | | |
| **Relevant medical conditions incl any allergies** | | | **Any relevant medication:** | |
| **Weight** | **Height** | | | **BMI** |
| **Blood test results**  Are there any blood test results relevant to the referral eg Lipids, IGT, blood sugars? | | | | |
| **Nutrition Support – please supply**  Must Score (must be 2+ to be accepted by the department for advice) …………………….  If unable to weigh please supply a MUAC (cm) ……………………. | | | | |
| **Alternative contact for patient** – please supply for Care Home, Ward and Nutritional Support Patients  **Name: Contact Number:**  **Relationship to Patient:** | | | | |

**Please send the completed form to the Berkshire Integrated hub on**

[**integratedhub@berkshire.nhs.uk**](mailto:integratedhub@berkshire.nhs.uk) **or Fax to 0300 3650400**