

For use by the Nutrition and Dietetics Department:

Date received: _____ Triaged by: _____
 Routine: Urgent:
 Info needed: _____

Department of Nutrition and Dietetics Referral Form

Please post to: Department of Nutrition & Dietetics, Hengrave House, Lowes Bridge, Torbay Hospital, Torquay TQ2 7AA
 Or email only if you have an NHS email account: tsdft.community.dietitians@nhs.net Tel: 01803 654396

Patient/Client Details

Name of Patient/Client: Date of birth:

NHS No. (if known) or Hospital No. (if known)

Patient/Client Address:
 Postcode:.....

Telephone no.: Mobile no.:

Lives in: Own home Nursing home Residential home Other:

Is the patient under Intermediate Care? Yes No Don't know

Are there any potential lone working concerns?: Yes No Don't know

If 'Yes', please state what these concerns are:

Name of GP and Surgery:

GP aware of referral: Yes No Don't know

Can the patient come to clinic? Yes No Don't know

Has the patient consented to Dietetic input? Yes No Don't know

Referral Details

Weight, including date taken (kg): _____ **Height (m):** _____ **BMI:** _____

Weight History over past 3-6 months: _____

MUST Score: _____

Reason for referral: _____

Current condition	Y/N
Grade 3 or 4 pressure sore	
Severe dysphagia- unable to manage solids	
Rapid clinical deterioration is anticipated and nutritional intervention may be beneficial e.g. Neurological Conditions such as MND	
Patients requiring PEG assessment or consideration of tube feeding	
Nutritional supplements are the sole source of nutrition	
Patients at high risk of hospital admission due to lack of support from other agencies	
Concerns about safeguarding or self-neglect	
Patients who live alone in their own home/isolated/care for a relative at home	

What actions have already been done?	Y/N
Food record charts (3 days if possible)	
High calorie, protein diet commenced	
High calorie milkshakes (homemade)	
Fortified milk	
Over the counter nutritional supplements e.g. Meritene, Complan	
Treating any underlying medical conditions e.g. pain, nausea, constipation/diarrhoea	
Prescribed nutritional supplements started: Type: Dose: Date started:	

Does the patient have swallowing difficulties: Yes No

Modified texture of food:

Modified texture of fluids:

(If yes and they haven't been assessed by Speech and Language Therapy, please also refer onto their team)

Medical Status

Current diagnosis:

Past medical history:

Social history:

Abnormal biochemistry:

Current medication:

Is there a known deteriorating condition?: Yes No

Is this person for End of Life Care?: Yes No

Is there a verbal or written Living Will/Advance Directive? Yes No

Is there an up to date TEP form (Treatment Escalation Plan) Yes No Don't know

Details:

Other relevant information: (e.g. hearing loss, behaviour issues, access

Referrer's Name: Role:

Date:

Referrer's Address:.....

Telephone/Mobile no.: E-mail:

Guidance

Link to Joint Formulary for advice on appropriate use of oral nutritional supplements

<https://southwest.devonformularyguidance.nhs.uk/formulary/chapters/9-blood-and-nutrition/9-5-2-nutrition-oral/formulary-oral-nutritional-supplements>

For videos on how to make fortified milk and use MUST

<http://www.torbayandsouthdevon.nhs.uk/services/nutrition-dietetics/support-videos/for-carers-and-health-care-professionals/must-screening/>

For information on MUST and local care plans (pages 7-10)

https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/G0526.pdf