Bexley Community Dietetic Service - Adults

Referral form - please email to BROMH.bromleyhealthcarereferrals@nhs.net

Bexley Community Dietitians, St Paul’s Cray Clinic, Mickleham Road, St Paul’s Cray, Orpington BR5 2RJ **Tel: 03003305777**

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| **PATIENT DETAILS** | | | | | | **REASON FOR DIETETIC REFERRAL** | | | | | | | |
| **Name** | |  | | | | **Poor Nutritional Intake** | | | | | Yes | | |
| **Date of Birth** | |  | | | | **Other reason (please specify)** | | | | | | | |
| **Gender** | | Male  Female | | | |
| **Home**  **Address** | |  | | | |
| **Postcode** | |  | | | | **Is the patient housebound?**  Yes [continue with this referral form]  [please note this is a domiciliary service for non-ambulatory patients. If the patient is able to attend clinics please refer to Dartford and Gravesham Dietetic Service.]  No | | | | | | | |
| **Tel No** | |  | | | |
| **Ethnicity** | |  | | | |
| **NHS No** | |  | | | | **Current mobility** | | | |  | | | |
| **NOK Name & Contact No** | |  | | | | **Care agency contact details (if applicable)** | | | |  | | | |
| **GP DETAILS** | | | | | | **NUTRITIONAL SUPPLEMENTS** | | | | | | | |
| **GP** |  | | | | | **Patient on Nutritional Supplements?** | | | | | | | Yes  No |
| **Surgery** |  | | | | | **Name** | | |  | | | | |
| **Address** |  | | | | | **Dose** | | |  | | | | |
| **Postcode** |  | | | | | **Starting date** | | |  | | | | |
| **Tel No** |  | | | | | **Tolerance** | | | Yes  No | | | | |
| **Fax No** |  | | | | | **Compliance** | | | Yes  No | | | | |
| **RELEVANT CONCERNS** | | | | | | **RELEVANT MEASUREMENTS** | | | | | | | |
| **Bowel type** | | |  | | | **Height :** | | | | | | **Date:** | |
| **Pressure ulcer**  location and grade | | | Yes  No | | | **Current Weight :** | | | | | | **Date:** | |
| **Swallowing difficulties** | | | | Yes  No | | **BMI :** | | | | | | **Date:** | |
| **Is patient on texture modified diet? -** Specify | | | | Yes  No | | **MUST Score :** | | | | | | **Date:** | |
| **Is patient on thickened fluids? -** Specify stage/level | | | | No  1  2  3 | | **3 - 6 month Weight History** | |  | | | | | |
| **MEDICAL DIAGNOSIS/PMH & MEDICATION** | | | | | | **RELEVANT SOCIAL INFORMATION** | | | | | | | |
| Has the patient been referred to the Bexley  Yes  No  Community SLT for swallowing difficulties?  Please attach prescription list and any recent blood results. | | | | | |  | | | | | | | |
| **Referrers Name & Job Title** | | | | |  | | **Contact No** | | | | | **Date** | |

