Bexley Community Dietetic Service – Adults

Referral form – Bexley Community Dietitians. Please email to [bromh.cccpod2refs@nhs.net](mailto:bromh.cccpod2refs@nhs.net)  
St Paul’s Cray Clinic, Mickleham Road, St Paul’s Cray, Orpington BR5 2RJ Tel: 0300 330 5777

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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]  [NB. this is a domiciliary service for non-ambulatory patients. If the patient is able to attend clinics please refer to Dartford & Gravesham Dietitians]  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 & 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** | | | | | | | |
| Please attach prescription list and any recent blood results | | | |  | | | | | | | |
| **Referrers Name & Job Title** | | |  | | **Date** | | | | |  | |

