Bexley Community Dietetic Service – Adults

Referral form – Bexley Community Dietitians. Please email to 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** |  |

