Bromley Community Adult Dietetic Service

Referral form please email to [bromh.cccpod2refs@nhs.net](mailto:bromh.cccpod2refs@nhs.net)  
Community Dietitians, Beckenham Beacon, 379 Croydon Road, Beckenham, BR3 3QL Tel: 0300 330 5777

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| **PATIENT DETAILS** | | | | | | **REASON FOR DIETETIC REFERRAL** | | | | | | | |
| **Name** | |  | | | | **Poor Nutritional Intake** | | | |  | | | |
| **Date of Birth** | |  | | | | **Pressure Ulcer**  location and grade | | | |  | | | |
| **Gender** | |  | | | | **Allergy**  please specify | | | |  | | | |
| **Home**  **Address** | |  | | | | **IBS** | | | |  | | | |
| **Postcode** | |  | | | | **Gastro condition**  please specify | | | |  | | | |
| **Tel No** | |  | | | | **Hyperlipidaemia** | | | |  | | | |
| **Ethnicity** | |  | | | | **Other**  please specify | | | |  | | | |
| **NHS No** | |  | | | | Patients requiring weight reduction advice can access commercial weight management groups through their GP | | | | | | | |
| **Is the patient housebound?** | |  | | | | Patients requiring specific diabetes dietary advice should be referred via SPE to the Bromley Diabetes Service by their GP | | | | | | | |
| **GP DETAILS** | | | | | | **NUTRITIONAL SUPPLEMENTS** | | | | | | | |
| **GP** |  | | | | | **Patient on Nutritional supplements?** | | | | | | |  |
| **Surgery** |  | | | | | **Name** | |  | | | | | |
| **Address** |  | | | | | **Dose** | |  | | | | | |
| **Postcode** |  | | | | | **Starting date** | |  | | | | | |
| **Tel No** |  | | | | | **Tolerance** | |  | | | | | |
| **Fax No** |  | | | | | **Compliance** | |  | | | | | |
| **RELEVANT CONCERNS** | | | | | | **RELEVANT MEASUREMENTS** | | | | | | | |
| **Bowel type** | | |  | | | **Height:** | | | | | | **Date:** | |
| **Skin integrity** | | |  | | | **Current weight:** | | | | | | **Date:** | |
| **Swallowing difficulties** | | | |  | | **BMI:** | | | | | | **Date:** | |
| **Is patient on texture modified diet? -** Specify | | | |  | | **MUST Score:** | | | | | | **Date:** | |
| **Is patient on thickened fluids?** – specify stage / level | | | |  | | **Weight history past 6 months:** | | |  | | | | |
| **MEDICAL DIAGNOSIS/PMH** | | | | | | **RELEVANT SOCIAL INFORMATION** | | | | | | | |
|  | | | | | |  | | | | | | | |
| **RELEVANT MEDICATION & BLOOD RESULTS** | | | | | | **APPOINTMENT LOCATIONS** | | | | | | | |
| Please attach prescription list and any recent blood results | | | | | | Patients will be routinely offered a clinic appointment face-to-face or via telephone as preferred | | | | | | | |
| **Referrers Name & Job Title** | | | | |  | | **Date** | | | |  | | |
| **Work Base Location** | | | | |  | | **Contact Number** | | | |  | | |