| **GSTT Integrated Care Dietetic Team Referral form (LAMP Team)**(GP Clinic, Domiciliary and Care Home Community Dietetic referrals – excluding Home Enteral Nutrition) |
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| **Please note, all fields must be completed including referrer details or the referral will be rejected****All referrals from GPs for dietetic outpatient clinics at GSTT need to be made via e-RS** |
| **\*Please indicate input required and forward completed referral to email address as detailed below:** |
| **\*Please tick appropriate location: Housebound** **[ ]  Care Home [ ]  Community/GP Dietitian Clinic [ ]** **Send referral to:** **GST-TR.referralslambethsouthwarkdietetics@nhs.net** |
| Lambeth and Southwark Home visit and Care Home service referral criteria (Oral Nutritional Support)* Adult patient - housebound or residing in a Care Home in Lambeth or Southwark
* MUST score ≥ 2 (s*ubjective criteria regarding nutritional concerns will be considered for patients)*
* For guidance see[www.bapen.org.uk/screening-and-must/must-calculator](http://www.bapen.org.uk/screening-and-must/must-calculator))
* Review of prescribed oral nutritional supplements (ONS)
* Nutritional concerns including unintentional weight loss relating to dysphagia/ texture modified diet
* Falls, long term conditions and/or pressure ulcer with concerns regarding nutritional status
 |
| **\*Date:**  | **\*Consent gained for referral:** Patient [ ]  Next of kin/carer [ ]   |
| **\*Reason for referral? \*referral will be returned if not completed\***  |
| \*Patient Name: | \*Address: | Telephone: |
| \*NHS:  | DOB:  | Age:  | Ethnicity:  |
| Next of Kin:  | Relationship:  | Tel:  |
| Other relevant NOK/carer info if applicable:  |
| \*GP Name: | \*Address: | \*Tel:  |
| \*Relevant medical history (including relevant biochemistry) | \*Current medication (including prescribed oral nutritional supplements)  |
| **GP referrals: Please complete above or attach EMIS ‘Brief Summary’ to include ‘Significant Past Problems’, ‘Investigations’ in past year, and all current ‘Medications’ (repeat and acute). Attach all relevant reports also.** |
| Weight: Date:  | Height: Date:  | BMI: Date:  |
| Weight history (weights & dates): (intentional / unintentional) | Nutritional screening score, e.g. Malnutrition Universal Screening Tool (MUST) score [*MUST Calculator*](http://www.bapen.org.uk/screening-for-malnutrition/must-calculator) *(adults):*  | Falls History (if applicable): |
| Social Situation (relevant social history and details, e.g. Package of care, key contacts etc): |
| Communication impairment? Yes **[ ]** No[ ]  Details:  | Translator required?Yes **[ ]**  No[ ]  Details/language: |
| \*Safeguarding issues? Yes **[ ]** No [ ]  Details:*(must complete for housebound patients*) |
| **Housebound only:**Known risk factors to home visiting? Yes **[ ]** No[ ]  Details: Barriers to gaining entry to the patient’s property e.g. key safe? Yes **[ ]** No [ ]  Details**:****Consent for Dietetic Team to use keysafe:** Yes **[ ]** No [ ]  |
| **Referrer Details: ALL FIELDS ARE MANDATORYPlease provide email address & contact number to support communication regarding this referral.**  |
| **Name of referrer:** | **Designation/discipline:** | **Date:** |
| **Team and Address:**  | **Telephone:** | **Email:** |
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