| **GSTT Integrated Care Dietetic Team Referral form (LAMP Team)** (GP Clinic, Domiciliary and Care Home Community Dietetic referrals – excluding Home Enteral Nutrition) | | | | |
| --- | --- | --- | --- | --- |
| **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**](mailto: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 MANDATORY Please provide email address & contact number to support communication regarding this referral.** | | | | |
| **Name of referrer:** | **Designation/discipline:** | | | **Date:** |
| **Team and Address:** | **Telephone:** | | | **Email:** |
| **Department of Nutrition & Dietetics, 1st Floor, Tower Wing, Great Maze Pond, London, SE1 9RT  Tel: 020 7188 2010** | | | | |