# Lewisham Primary Care Adult Dietetic Service Referral Form

**To be completed *IN* *FULL* by the referring Health Professional – email to** **bromh.lewishamdietetics@nhs.net**

## REASON FOR DIETETIC REFERRAL

**Practice based clinic:**

❒ Hyperlipidaemia ❒ Hypertension ❒ IBS ❒ Allergy ❒ Gastro condition (please specify):

❒ Diabetes ❒ Other (please specify):

**Tier 3 Exclusive Morbid Obesity clinic:**

❒ Morbid Obesity BMI >40

(The above option is a 1:1 services at neighbourhood host sites)

If BMI >40 or >35 with Type 2 Diabetes and willing to participate in multi-disciplinary **group-based** programme delivered in community please consider referral to GSTT multi-disciplinary South East London Tier 3 Healthy Weight Programme via eRS found under Dietetics/Weight Management or email GST-TR.tier3@nhs.net

**Nutrition support :**

❒ MUST score 2 or more

❒ Patient discharged from hospital on ONS

❒ Patient requires review of prescribed ONS

**What advice has been given e.g. soft diet, fortified diet, previous weight management referrals**

## PATIENT DETAILS F/M

Surname:

First name:

Address:

Postcode:

Home Tel:

Mobile:

DOB:

NHS No**:**

Ethnicity:

Interpreter required (tick for yes)❒

**Person to contact to make an appointment:**

Name:

Tel:

Relationship to patient:

## CONSULTATION DETAILS

Patients will be routinely offered an appointment at their GP Practice, host site weight management clinic or nursing/care home as applicable. Home visits will be offered at the discretion of the dietitian.

## GP DETAILS

Name:

Surgery:

Address:

Postcode: Tel:

**Does the GP visit patient at home?** Yes ❑ No ❑

## RELEVANT MEASUREMENTS

Height: Date:

Weight: Date:

BMI: Waist Circumference:

Weight 3-6mo ago: Date:

MUST Score: Date:

**RELEVANT BLOOD RESULTS (including date)**

HbA1C: TSH:

Cholesterol: Triglycerides:

HDL: LDL:

## MEDICAL DIAGNOSIS/PMH

## RELEVANT MEDICATION

**ANY OTHER RELEVANT INFORMATION**

**RELEVANT SOCIAL INFORMATION** (e.g. wheelchair user, communication difficulties/learning disabilities, carers and any other relevant information)

**REFERRERS NAME:** **REFERRERS TITLE:**

**BASE:** **CONTACT NUMBER**:

**SIGNATURE:** **DATE:**