Community Dietitian Referral Form

West Suffolk
NHS Foundation Trust

Referrals are accepted from all healthcare professionals.
Please print clearly and fill in all relevant sections - incomplete referrals will be returned.

Please see referral criteria in the accompanying document and note that we are **not** commissioned to provide the following services to West Suffolk / South Norfolk patients:

- **Adult Allergy:** refer to Addenbrookes Allergy Department via ERS.
- **Adult Eating Disorders:** refer via the Access and Assessment team, see www.nsft.nhs.uk/Our-services/Pages/Access-and-Assessment-Service-Suffolk.aspx
- **Adult Disordered Eating:** please see following websites to BEAT beateatingdisorders.org.uk and MIND www.mind.org.uk
- **Adult Weight Management:** Suffolk patients, refer to One Life Suffolk: onelifesuffolk.co.uk/services/adult-weight-management/ Norfolk patients, refer to Slimming World: www.norfolk.gov.uk/care-support-and-health/health-and-wellbeing/adults-health/weight-management

1. Patient details		
Name:		Date of birth:
NHS no:	Current place of residence:	
Address:		
Tel. numbers:		
GP name, surgery & tel. no:		
2. Consent		
Has the patient consented to this referral? No ☐ Yes ☐ Have you referred in the patient's best interests because they lack capacity? No ☐ Yes ☐		
3. Patient information and history		
Does patient receive home visits from GP? No ☐ Yes ☐		
Does the patient have a disability? No ☐ Yes ☐	Are reasonable adjustments required? No ☐ Yes ☐	
please specify		
Is an interpreter needed? No ☐ Yes ☐	Does the patient have communication difficulties? No ☐ Yes ☐	
please specify		
Brief medical history:		
Current medications:		

Are there safeguarding concerns? No ☐ Yes ☐

please specify

4. Reason for referral

Diabetes type 1 ☐ Diabetes type 2 ☐ Impaired glucose tolerance ☐

Renal ☐ Coeliac disease ☐ Nutrition support ☐ **please complete section 5**

Inflammatory Bowel Disease ☐ Irritable Bowel Syndrome ☐ **please complete section 6**

Other Gastrointestinal disease ☐ *specify:*

Nutritional deficiencies ☐ *specify:*

Cardiovascular disease ☐ *specify:*

Other ☐ *specify:*

5. Nutrition Support referrals only – MUST screening results

Nutrition Support referrals will only be accepted for patients with a MUST score of 2 and above unless specified additional risk factors present

For further help using MUST please see: www.bapen.org.uk/screening-and-must/must-calculator

Step 1	Step 2	Step 3	Step 4
Current weight ______ kg Height ______ m BMI ______ kg/m^2 **score** ______	Weight loss over past 3-6 months ______ kg Percentage weight loss ______ % **score** ______	Only use step 3 if the patient is acutely ill **and** there has been, or likely to be, no nutritional intake for more than five days. Acute disease effect **score** ______	**Overall MUST score** Sum of scores from steps 1 + 2 + 3 ______

Nutrition Support referrals only – additional risk factors

Rapid weight loss more than 10% in 3-6 months ☐ Breathing difficulties i.e. COPD ☐

Oncology / palliative care ☐ Swallowing difficulties ☐

Pressure sores or poor wound healing ☐ *specify grade & location:*

Nutrition Support referrals only – action already taken

Homemade milkshake recipes given ☐ Food fortification advice given ☐ Extra snacks recommended ☐

Other:

6. Irritable Bowel Syndrome (IBS) referrals only

Please ensure that all the following sections are considered and ticked before submitting

☐ I confirm that the patient meets Rome IV Diagnostic Criteria for IBS:
Abdominal pain (at least once a week for 3 months) associated with two or more of the following:

- pain related to defecation
- change in stool frequency
- change in form (appearance) of stool.

☐ I confirm that there are no red flag symptoms present.

- Unexplained weight loss, greater than 5% usual weight
- Rectal bleeding
- Family history of bowel or ovarian cancer or IBD
- Unexplained anaemia
- Rectal or abdominal mass
- Raised inflammatory markers
- Nocturnal symptoms, including diarrhoea

☐ I include the following investigations in support of the referral

☐ Faecal calprotectin (results <200µg/g)

☐ Blood test

- Full blood count
- CRP
- Coeliac Antibodies

☐ I include any available weight history

IBS referrals – additional notes

Referrer details

Name & job title:

Date:

Location / address:

Signed:

Tel no:

Please send this form by email to:
communitydietitians@wsh.nhs.uk

Community Dietitians
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