Community Dietitian Referral Form

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

NHS
West Suffolk
NHS Foundation Trust

Please see referral criteria: WSFT Adult Community Dietetic Referral Criteria - Final August 2022 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 A list of services available to adults. | Norfolk and Suffolk NHS
- **Adult Disordered Eating** including **Avoidance Restrictive Food Intake Disorder (ARFID):** see BEAT beateatingdisorders.org.uk for services in your area.
- **Adult Weight Management:** For Suffolk patients, refer to Feel Good Suffolk: Home - Feel Good Suffolk. For Norfolk patients, refer to Slimming World or Your Health Norfolk: Help with weight management - Norfolk County Council

GPs – For patients residing in a care home, please ask care home staff to complete the referral form and send to us with all required documents. This information and the link to the form can be found within the Local Action Plan for care homes:11. West Suffolk MUST local action plan 202122

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 ☐ *If the patient lacks capacity, who is the named contact?* Name: Relationship: Phone number:

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

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	Weight loss over past 3-6 months	kg	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.		**Overall MUST score**
Height	m					
BMI	kg/m^2	Percentage weight loss	%	Acute disease effect **score**		Sum of scores from steps 1 + 2 + 3
score		**score**				

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 ☐ S*pecify Category:*

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 checked 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
West Suffolk NHS Foundation Trust
Maple House, 24 Hillside Business Park
Bury St Edmunds
IP32 7EA
Tel: 01284 713668