

**NUTRITION & DIETETIC SERVICE REFERRAL FORM – Community services**

**Early Supported Discharge referral 🞎 urgent response required**

**PATIENT DETAILS:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Surname** |   | **Title** |  | **DOB** |  |
| **Forename(s)** | **Sex** |  **Male** **[ ]  Female** **[ ]**  |
| **Address****(include postcode)** | **Daytime** **telephone number** |  |
| **H&C number** |  | **Mobile No:** |  |

**REFERRAL DETAILS:**

|  |  |
| --- | --- |
| **Diagnosis/ Reason for referral** |      |
| **Patient aware of diagnosis and referral** | **Yes** [ ]  **No** **[ ]**  |

**MEDICAL DETAILS:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Weight (+ date)** |  | **Centile** |  |  **Glucose** |  |
| **Height** |  | **Centile** |  |  **HbA1c** |  |
| **BMI** |  | **Lipids** |  |
| **Medication** |  | **Other** |  |
| **Relevant medical/ other information**  |       | **MUST score** |       |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Interpreter required**  | **Yes [ ]  No [ ]**  | **Language required** |       |
| **Professionals known to patients (paediatrician, HV etc)** | **Yes** **[ ]  No** **[ ]  Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Is the child:** **On the Child Protection register?** | **Yes [ ]** **No [ ]**  | **A Looked After Child?** | **Yes [ ]** **No [ ]**  | **A Child in Need?** | **Yes [ ]** **No [ ]**  |
| **Relevant social circumstances:** |   |
| **LONE WORKER ISSUE** | **Are there any potential risks to the Dietitian treating alone ?****Yes [ ]  No [ ]  If yes, please specify:**       |

**GP DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |       | **Practice code** |       |
| **Address** |       | **Cypher code** |       |
| **Tel. number** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name/Signature** **of referrer** |       | **Designation** |       | **Date** |       |
| **Location** |       | **Contact number** |       |

**Email referral directly to AHP Central Booking unit:** **ahp.cbu@southerntrust.hscni.net** **OR send completed referral form to: AHP Central Booking Unit, Ramone Building, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ**

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**DIETETIC USE ONLY:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date referral received** |       | **Priority Status** |       | **POC** |       |
| **Date of appt/location** |       | **Clinical Manager No.** |       | **ICD10 code**  |       |