[24](http://www.hpssjobs.com/org_view.asp?OrgID=24)

**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**](mailto: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**

**------------------------------------------------------------------------------------------------------------------------------------**

**DIETETIC USE ONLY:**

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