**COMMUNITY DIETETIC REFERRAL**

**Private and Confidential**

Stewart Smith House, Royal Devon and Exeter Hospital (Wonford). Tel: 01392 402576

For GP Practice use

Please complete and refer via e-Referrals Service

[DRSS-Eastern-Dietetic-NEW Devon CCG -99P](https://nww.ebs.ncrs.nhs.uk/main)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details: Section 1** | | | | | | | | |
| **NHS Number:** | <NHS number> | | | **Date of Birth:** | | <Date of birth> | | **Sex:** <Gender> |
| **Patient Name:** | <Patient Name> | | | **Marital Status:** | | <Marital Status> | | |
| **Address:**  <Patient Address> | | | | | | | | |
| **Postcode:** | <Patient Address> | | | **Email: Address:** | <Patient Contact Details> | | | |
| **Preferred Tel:**  <Patient Contact Details> | | | **Home Tel:**  <Patient Contact Details> | | **Mobile Tel:**  <Patient Contact Details> | | | |
| **Referring GP Details:** | | | | | | | | |
| **Name:** | | <Sender Name> | | **Registered GP:** | | | <GP Name> | |
| **Practice Name and Address:** | | <Organisation Address> | | | | | | |
| **Tel No:** | | <Organisation Details> | | | | | | |

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| **Medical diagnosis and clinical details (Please attach GP summary)** | | |
| Reason for Referral: | Select boxes as appropriate | |
| To help with weight gain  Regarding diabetes  Regarding IBS  Regarding gluten free advice  To increase intake of specific nutrient (e.g. iron, calcium, etc)  Regarding a healthy balanced diet  To improve nutritional intake (eg fussy eater)  Pre Peg tube assessment  To helpwith lowering cholesterol level  Other: please specify | |  |
| Comments (e.g. current investigations, second address, etc.) | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Weight (Kg) | **<Latest Weight>** | | Height: | **<Latest Height>** | Body mass index (BMI) | **<Latest BMI>** |
| If height and weight unknown is this referral: Urgent  Routine  Non-applicable | | | | | | |
| Weight history if known:  **<Numerics(table)>** | | | | | | |
| Relevant blood test results (if diabetes please include Hba1c / for IBS please exclude coeliac disease via IgA Ttg. If nil relevant to specify that)  **<Numerics(table)>** | | | | | | |
| Date of Request | | **<Today's date>** | | | | |

**Relevant Past Medical History:**

<Problems(table)>

**Medications:**

<Medication(table)>