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| **Paediatric Community Dietetic Referral Form** | | | | | |
|  | | | | | | |  | |  | |  | |  |  | | |  | |  | |  | |
| **PLEASE SEND COMPLETED FORM TO:** |  | | | | |
|  | Tel: 01752 432240 (appointments line) | | | | |
| **Email:** [plh-tr.Community-Dietetics@nhs.net](mailto:plh-tr.Community-Dietetics@nhs.net) | Tel: 01752 433228 (community office) | | | | |
|  |  | | | | |
| **Patient Details** | ***To prevent delays, please ensure the form is completed in full*** | | | | |
| Title: | Name: | | | | |
| DOB: | NHS No: | | | | |
| Telephone No: | Mobile: | | | | |
| Email: | | | | | |
| Address: | | | | | |
|
|
| Postcode: | | | | | |
| Carer(s) Details: | | | | | |
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| **Reason for Referral** | | | | | |  | |  | |  | |  | | |  |  | |  | |
| Weight: (kg) | Centile: | Date: |  |  | |
| Height: (m) | Centile: | Date: |  |  | |
| BMI: (kg/m²) | Centile: | Date: |  |  | |
|  | | | | | |  | |  | |  | |  | | |  |  | |  | | | |
| |  | | --- | | Weight History in the past 12 months: | | Reason for Referral: | | Desired Outcome of Dietetic Intervention: |   **Medical Status** | | | | | |  | |  | |  | |  | | |  |  | |  | | | |
| Current Diagnosis:  Current Medication: (please attach repeat prescription, including specialist formula)  Past Medical History:  Relevant Biochemistry: | | | | | | |  | |  | |  | |  |  | | |  | |  | |  | | |
| **Other Relevant Information or Special Requirements**  Has the parent or representative consented to dietetic input? Yes □ No □  Are there any potential lone working concerns i.e. hazards/safeguarding issues? Yes □ No □ | | | | | |
|  | | | | | | |  | |  | |  | |  |  | | |  | |  | |  | | |
| **If yes, please provide details:** | | | | |
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|  | | | | | | |  | |  | |  | |  |  | | |  | |  | |  | | |
| Please provide contact details of other health and social care services / professionals / agencies / learning disability services who are involved with this patient: | | | | | |
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**Referrers Details**

|  |  |
| --- | --- |
| Job Title: | |
| Address:  Postcode: | |
| Telephone No: | Email: |
| Referrers Signature: | Print Name: |
| Date of Referral: | GP Consent/Aware of Referral: |

**GP Details**

|  |
| --- |
| GP Name: |
| GP Address: |