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| **Paediatric Community Dietetic Referral Form** |
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| **PLEASE SEND COMPLETED FORM TO:** |  |
|  | Tel: 01752 432240 (appointments line) |
| **Email:** 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: |   |   |
|  |  |  |  |  |  |  |  |
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| 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**

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

**GP Details**

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| GP Name: |
| GP Address: |