**Paediatric Dietitian referral for infants
with cow’s milk protein allergy (CMPA)**

The RD&E are providing a new ‘rapid access clinic’, which aims to see new referrals for suspected CMPA within 2 weeks.

Please refer infants you suspect to have symptoms of CMPA. We will see breast fed and formula fed infants, and provide recommendations for formula prescriptions where appropriate, thereby reducing the need for this to be initiated in primary care.

Please continue to refer infants with confirmed CMPA.

GPs can refer to this service via e-referrals, using this form if convenient. Or for those teams without access to e-referrals (e.g. health visitors), you can refer by completing this form and sending it to rde-tr.CMPAdietitian@nhs.net .

For the management of CMPA and any other related issue, please refer to your local guidance in addition to considering the following:

* NICE guideline for GORD in children (2015) - <https://www.nice.org.uk/guidance/ng1>
* NICE guideline for faltering growth (2017) - <https://www.nice.org.uk/guidance/ng75>
* iMAP guideline, available via GP infant feeding network - <https://gpifn.org.uk/imap/>

|  |
| --- |
| **Patient Details:** |
| **NHS Number:** |  | **Date of Birth:** |  |
| **Patient Name:** |  | **Gender:**  | **F / M** |
| **Parent/ Guardian 1 Name:**  |  | **Relationship:** |  |
| **Address:** |  |
| **Post code:**  |  | **Email address:**  |  |
| **Home Tel No:**  |  | **Mobile Tel No:**  |  |
| ***If the child has a second address, please add parent name and details below:*** |
| **Parent/ Guardian 2 Name:**  |  | **Relationship:** |  |
| **Address:** |  |
| **Post code:**  |  | **Email address:** |  |
| **Home Tel No:** |  | **Mobile Tel No:**  |  |
| **Please tick if both addresses should be sent correspondence regarding appointments:** |  |
| **GP Details:** |
| **Name:** |  |  |
| **Practice Name:** |  |  |
| **Practice Address:** |  |  |
| **Tel No:** |  |  |
| **Referrer Details (if not GP details above):**  |
| **Name:** |  |  |
| **Profession:** |  |  |
| **Address:** |  |  |
| **Tel No:** |  |  | **Email address:**  |  |

|  |
| --- |
| **History:** |
| **Patient age at time of referral:** |  | **Feeding method** **(breast fed/ formula name):** |  |
| **Symptoms:** | [ ]  Reflux[ ]  Vomiting[ ]  Colic / abdominal pain [ ]  Loose stools[ ]  Constipation [ ]  Mucous in stools[ ]  Blood in stool (please consider Paediatric referral)[ ]  Respiratory symptoms[ ]  Eczema[ ]  Rashes [ ]  Faltering growth [ ]  Other For all of the above, please provide relevant additional information below: |
| **Medications and effect:**  |  | **Breast feeding support:** | Yes/ No  |
| **Recommendations for dietary exclusions and/or specialist formulas:**  |  |

|  |
| --- |
| **Growth measurements:** |
| **Date:**  | **Birth weight:** |  | **Current weight:** |  | **Length (cm):** |  |
| **Birth weight centile:** |  | **Current weight centile:** |  | **Length centile:** |  |
| **Growth summary/ additional information:** |

|  |
| --- |
| **Any relevant family issues or safeguarding information:** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |