**CONFIDENTIAL**

**Enteral Feeding Community Dietetic Referral**

**COMMUNITY NUTRITION AND DIETETIC SERVICE**

***Please complete shaded areas on BOTH sides with essential information***

***in BLOCK CAPITALS.***

***If e-registration is not completed, please complete all the information***

***(shaded and unshaded areas).***

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*Patient’s Name: (PRINT)** | | | | | | **\*G.P. Name & Surgery:** | | | | |  |
| **\*Surname:** | |  | | | |  | | | | |
| **\*Forenames:** | |  | | | |  | | | | |
| **\*Title: Mr/Mrs/Miss/Ms/Other:** | | | | | | **Surgery Address & Contact Details:**  **Patient Surname: First Name:** | | | | | |
| **\*Date of Birth:** | | | |  | |  | | | | | |
| **\*Address of Patient:** | | | | |  |  | | | | | |
|  | | | | | |  | | | | | |
|  | | | | | | **Post Code:** | | | | | |
|  | | | | | | **Tel. No:** |  | | | | |
| **Post Code:** | | | | | | **Fax No:** |  | | | | |
| **Tel. No (H)** |  | | | | | **Referral Source:** | | | | | |
| **Tel. No (M)** |  | | | | | **\***Referral made by: | | | |  | |
| **Tel. No (W)** |  | | | | | Location/Work Base: | | | |  | |
| **Email:** |  | | | | | Referrers Tel. No: | | | |  | |
| **\*NHS Number:** | | |  | | | **\***Referral Date: | | | |  | |
|  | | | | | | **Patient Classification:** | | | | | |
| **\*Ethnicity:** | | | | | | Gen. Community | | | | Paediatric | |
| **Religious/Spiritual beliefs:** | | | | | |
| **\*Gender:** | | **Male Female** | | | | Mental Health | | | | Learning Disability | |
| **Allergies:** | | | | | | **AUTHORISED BY: (Office use only)** | | | | | |
|  | | | | | | Name: | |  | | | |
|  | | | | | | Accepted date: | |  | | | |
|  | | | | | | RIO caseload: | |  | | | |
|  | | | | | |  | |  | | | |
|  | | | | | | Action: | |  | | | |
| **Alternative Contact Details:** | | | | | |  | | | | | |
| **1St Contact** | | | | | | **2nd Contact** | | | | | |
|  | | | | | |  | | | | | |
| Relationship: eg. carer, key worker, parent | | | | | | Relationship: e.g. carer, key worker, parent | | | | | |
| Name: | | | | | | Name: | | | | | |
| Address: | | | | | | Address: | | | | | |
|  | | | | | |  | | | | | |
|  | | | | | |  | | | | | |
| Post code: | | |  | | | Post code: | | |  | | |
| Tel. No (H) | | | | | | Tel. No (H) | | |  | | |
| Tel. No (M) | | | | | | Tel. No (M) | | |  | | |
| Tel. No (W) | | | | | | Tel. No (W) | | | | | |

**CONTINUED OVERLEAF**

**clinical details and special instructions**

***Please complete shaded area with essential information in BLOCK CAPITALS***

|  |  |
| --- | --- |
| **\*Reason for Referral:** | |
| **\*Relevant Medical History:** | |
| **Medication:** | **Biochemistry:** |
| **Consent given to be weighed/measured: Yes / No / Not applicable**  **Current weight (kg) (include date):\_\_\_\_\_\_\_\_\_\_\_ Height (m):\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_** | |

**Please tick relevant boxes:**

**Priority**: Urgent Routine

Interpreter Required Home Visit Required

Patient consented to outpt appt Key Safe Number

**\*Referrer’s signature ………………………………………………………… ……**

**\*Referrer’s contact details (include work base and email address)**

**……………………………………………………………………………………………**

**……………………………………………………………………………………………**

**Date ……………………………………………………………………………….…….**

**Please send referral by email to:** [***bht.communitydietitians@nhs.net***](mailto:bht.communitydietitians@nhs.net)

**Amersham Community Dietitians Tel:** 01494 734825.

Please Note: Fields marked with an **asterisk\*** and bold are mandatory – forms will be returned if these field are not completed.

**FAO Name of Dietitian:** ……………………… **Date telephoned to transfer**: …………….

**Transfer of dietetic responsibility** **For information only**

**Feeding regime:**

|  |  |  |
| --- | --- | --- |
| **Feed type:** |  | |
| **Delivery** | Pump / Bolus *(delete as appropriate)* | |
| **Pump feeding regime:** | Rate: | Length of time: |
| **or Bolus feeding regime:** | Volume of bolus: | No. of boluses: |
| **Suggested times:** |  | |
| **Water Volume:** |  | |
| **Delivery** | Flushes / Flexitainer *(delete as appropriate)* | |
| **Suggested times:** |  | |
| **GP px of feed requested** | Yes / No *(delete as appropriate)* | |

**Oral diet:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Any SLT recommendations?** | Date: |  | Diet: |  | | Fluids: |  |
| **Details of food intake**  (e.g. foods preferred, supplements) |  | | | | | | |
| **Est. oral energy/protein intake** | kcal | | | | g protein | | |

**Tube information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Make and size:** |  | | |
| **Date inserted:** |  | Insertion by: | Endoscopy / radiology |
| **Route:** | Gastrostomy / Jejunostomy / Other…………………*(delete as appropriate)* | | |
| **Comments:** |  | | |

**Training given:**

|  |  |
| --- | --- |
| **To who?:** |  |
| **Date:** |  |
| **Outcome:** |  |

**Monitoring:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Weight changes/Hx:** | Date | Weight | Date | Weight |
|  |  |  |  |
|  |  |  |  |
| **Anthropometric measures:** | Measure used | Date | Measurement | |
|  |  |  | |
|  |  |  | |
| **Tolerance comments:** | Bowels: |  | | |
| Additional Comments: | | | |

**Suggested follow-up:**

|  |  |
| --- | --- |
| **Location:** | Home / Nursing home / Community hospital / Other……………………… |
| **Time period:** |  |

**Abbott e-Registration completed** **e-BANS completed**

**Copy of GP Px letter enclosed**