

**PAEDIATRIC DIETETIC REFERRAL**

|  |  |  |
| --- | --- | --- |
| **Date of referral :** | **SMH /WH** | **In patient / Out patient**(delete as appropriate) |
| **Name of referrer:** (please print) | **Ward / Department and Contact no:** | **Patient Consultant:** |
| **Patient Details:** (or patient sticker)**Name: Date of Birth:** **Address:** **Hospital no: NHS no:** | **Weight:****Height:** |
| **CLINICAL DETAILS (including diagnosis):** |
| **REASON FOR REFERRAL:** |
|  |
| **IN PATIENT** |
| **STAMP (Nutritional Screening) Score:****Has the STAMP action plan been implemented?** Yes / No  | **Expected date of discharge:** |
| **All referrals: please telephone or bleep Dietetic Department with:** ward, patient name, hospital number, reason for referral  **SMH: ext 5775 Bleep 765 WH: ext 5776** **Telephoned: □ Date/Time: Signature:** |
| Please leave the completed referral in the front of the medical notes for the dietitian to collect. |
|  |
| **OUT PATIENT** |
| **GP:****Surgery:** | **Patient’s Daytime contact no:** **Mobile no:** |
| **If translator needed,** **specify language:** |
| **Relevant medication/biochemistry:** |
| **Out patient referral form:** Please send to Dietetic Department via internal mail or email. Do not fax. |