Bucks-Hosp-logos- colour

**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. | | | | |