Community Adult Dietetic Service

Referral form for Bromley Healthcare Staff please email to [bromh.cccpod3refs@nhs.net](mailto:bromh.cccpod3refs@nhs.net)

Community Dietitians, Beckenham Clinic, 14 The Crescent, Beckenham, BR3 1DU

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | | | | | | **REASON FOR DIETETIC REFERRAL** | | | | | | |
| **Surname** | |  | | | | **Poor Nutritional Intake** | | | |  | | |
| **First Name** | |  | | | | **Pressure Ulcer**  location and grade | | | |  | | |
| **Gender** | |  | | | | **Allergy**  please specify | | | |  | | |
| **Home**  **Address** | |  | | | | **IBS** | | | |  | | |
| **Mobile No** | |  | | | | **Gastro condition**  please specify | | | |  | | |
| **Tel No** | |  | | | | **Hyperlipidaemia** | | | |  | | |
| **Ethnicity** | |  | | | | **Other**  please specify | | | |  | | |
| **NHS No** | |  | | | | Patients requiring weight reduction advice can access commercial weight management groups through their GP | | | | | | |
| **Is the patient housebound?** | |  | | | | Patients requiring specific diabetes dietary advice should be referred via SPE to the Bromley Diabetes Service by their GP | | | | | | |
| **GP DETAILS** | | | | | | **NUTRITIONAL SUPPLEMENTS** | | | | | | |
| **GP** |  | | | | | **Patient on Nutritional supplements?** | | | | | |  |
| **Surgery** |  | | | | | **Name** | |  | | | | |
| **Address** |  | | | | | **Dose** | |  | | | | |
|  |  | | | | | **Starting date** | |  | | | | |
| **Tel No** |  | | | | | **Tolerance** | |  | | | | |
| **Fax No** |  | | | | | **Compliance** | |  | | | | |
| **RELEVANT CONCERNS** | | | | | | **RELEVANT MEASUREMENTS** | | | | | | |
| **Bowel type** | | |  | | | **Height :** | | | | | | |
| **Skin integrity** | | |  | | | **Current Weight :** | | | | | | |
| **Swallowing difficulties** | | | |  | | **BMI :** | | | | | | |
| **Is patient on texture modified diet? -** Specify | | | |  | | **MUST Score :** | | | | | | |
| **Is patient on thickened fluids? –** Specify stage | | | |  | | **Weight history past 4 months** | | |  | | | |
| **MEDICAL DIAGNOSIS/PMH** | | | | | | **RELEVANT SOCIAL INFORMATION** | | | | | | |
|  | | | | | |  | | | | | | |
| **RELEVANT MEDICATION & BLOOD RESULTS** | | | | | | **APPOINTMENT LOCATIONS** | | | | | | |
| Please attach prescription list and any recent blood results | | | | | | Patients will be routinely offered a clinic appt at either; Beckenham Beacon, St Paul’s Cray or the Willows Clinic | | | | | | |
| **Referrers Name & Job Title** | | | | |  | | **Date** | | | |  | |
| **Work Base Location** | | | | |  | | **Contact Number** | | | |  | |