**Greenwich Adult Dietetics (Malnutrition)**

**Food First Team Referral form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | |
| Surname: | | Forename: | | | |
| DOB: | | NHS No: | | | |
| Address: | | Tel.  Tel. Mobile  Other contact (Carer/ next of kin): | | | |
| Ethnicity: | Interpreter Required? □No □Yes. Language: | | | | |
| **GP Details:** | **GP Address:** | | | | |
| **Is this patient Housebound?**  □ **Yes** □ **No** | **Consent for referral?:** Patient □ Carer □ In best interests □ | | | | |
| **Medical History:** | | **Medications list:** | | | |
| **Reason for referral / Other comments / Access information: (key safe, unable to answer the door/phone, nursing home)** | | | | | |
|  | | | | | |
| **MALNUTRITION UNIVERSAL SCREENING TOOL**  *Essential for acceptance of this referral (See page 2. for reference)* | | | | | |
| Current weight: Date: | | | Height: | | BMI (Kg/m2): |
| Mid-Upper Arm Circumference measurement (if unable to weigh): Date: | | | | | |
| Weight History: | | | | | **MUST Score:** |
| **Is the patient on nutritional supplements?** □ **Yes** □ **No**  Details: | | | | | |
| **Referrer details:** | | | | | |
| Name: | | | | Tel: | |
| Address: | | | | Signature: Date: | |

**Please return completed form via:**

**Email**. [oxl-tr.dieteticreferrals@nhs.net](mailto:oxl-tr.dieteticreferrals@nhs.net)

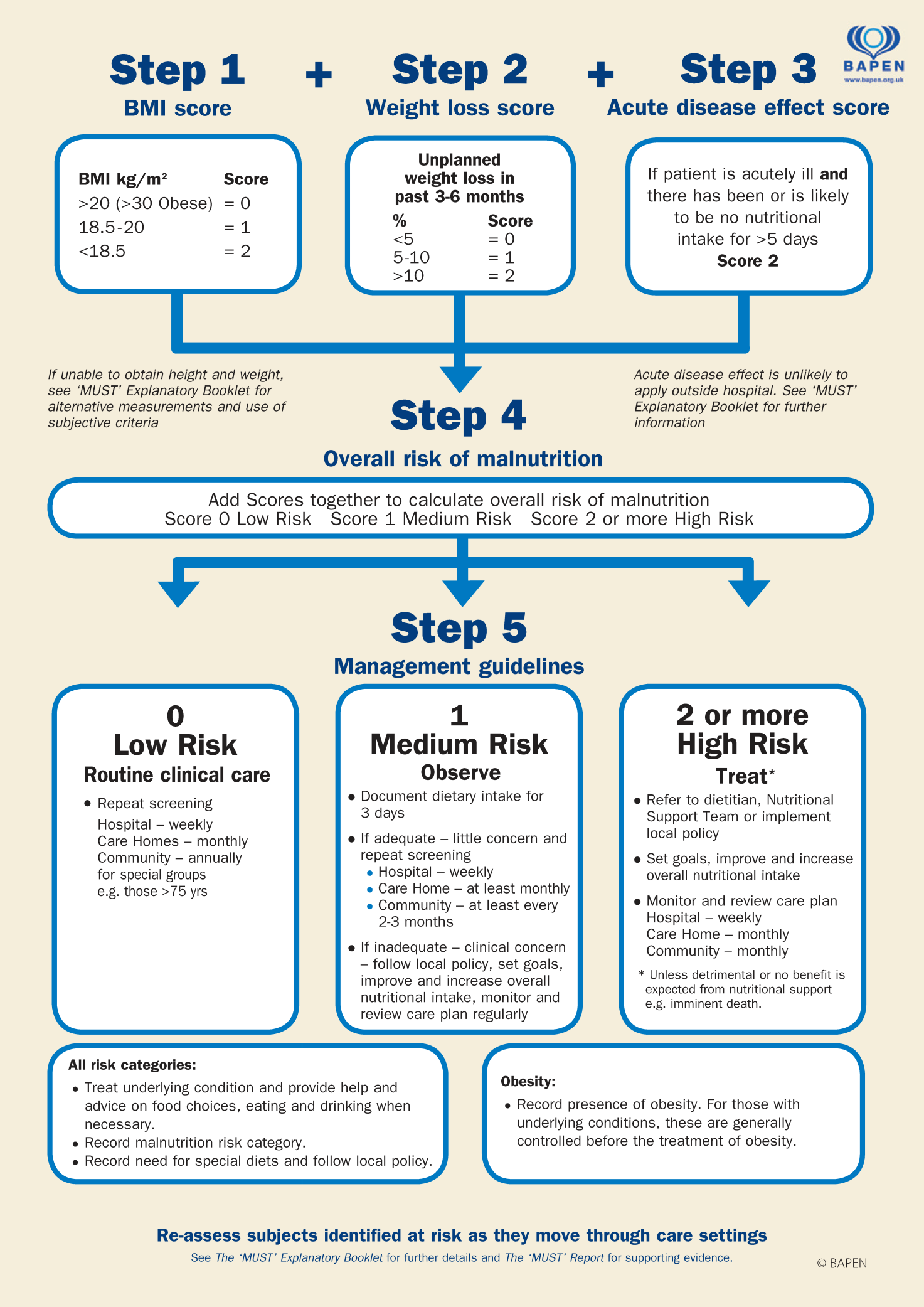
**Fax**. 020 8836 8643 (please call to confirm receipt of fax: 020 8836 8652)

**Post**: Dietetics, Room F42, Memorial Hospital, Shooters Hill, SE18 3RG

**INCOMPLETE FORMS WILL BE REJECTED**

For Referrals to Primary Care Dietetics, Please use NHS E-Referrals

**Malnutrition Universal Screening Tool (MUST)**



‘MUST’ Calculator: <http://www.bapen.org.uk/screening-and-must/must-calculator>

‘MUST’ Toolkit: <http://www.bapen.org.uk/screening-and-must/must/must-toolkit>