# Bromley HealthcareLewisham Primary Care Adult Dietetic Service

#  Referral form

TO BE COMPLETED *IN* *FULL* BY THE REFERRING HEALTH PROFESSIONAL & Email to generic address below

 EMAIL **bromh.lewishamdietetics@nhs.net**

## REASON FOR DIETETIC REFERRAL

**Practice based clinic:**

❒ Hyperlipidaemia ❒ Hypertension ❒ IBS ❒ Allergy ❒ Gastro condition (please specify):

❒ Diabetes ❒ Other (please specify):

**Tier 3 Exclusive Morbid Obesity clinic:**

❒ Morbid Obesity BMI >40

(The above option is a 1:1 services at neighbourhood host sites)

If BMI >40 or >35 with Type 2 Diabetes and willing to participate in multi-disciplinary **group-based** programme delivered in community please consider referral to GSTT multi-disciplinary South East London Tier 3 Healthy Weight Programme via eRS found under Dietetics/Weight Management or email GST-TR.tier3@nhs.net

**Nutrition support :**

❒ MUST score 2 or more

❒ Patient discharged from hospital on ONS

❒ Patient requires review of prescribed ONS

**What advice has been given e.g. soft diet, fortified diet, previous weight management referrals**

## PATIENT DETAILS F/M

Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firstname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_

HomeTel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NHSNo**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_

Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intepreter required (tick for yes)❒

**Person to contact to make an appointment:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## CONSULTATION DETAILS

Patients will be routinely offered an appointment at their GP Practice, host site weight management clinic or nursing/care home as applicable.

Home visits will be offered at discretion of the dietitian

## GP DETAILS

Name

Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode:\_\_\_\_\_\_\_\_\_\_\_

Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the GP visit patient at home? Yes ❑ No ❑**

## RELEVANT MEASUREMENTS

Height: \_\_\_\_\_\_\_\_\_ Date of Recording \_\_\_\_\_

Weight: \_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

BMI: \_\_\_\_\_\_\_\_\_\_ Waist Circumference: \_\_\_

Weight 3-6 months ago: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

MUST Score: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**RELEVANT BLOOD RESULTS (including date)2/1/19**

HbA1C \_\_\_\_\_\_\_\_\_\_ TSH: \_\_\_\_\_\_\_\_\_

Cholesterol: \_\_\_\_\_\_\_\_\_\_ Triglycerides: \_\_\_\_\_\_\_\_\_\_

HDL: \_\_\_\_\_\_\_\_\_\_\_ LDL: \_\_\_\_\_\_\_\_\_\_

## MEDICAL DIAGNOSIS/PMH

## RELEVANT MEDICATION

**ANY OTHER RELEVANT INFORMATION**

**RELEVANT SOCIAL INFORMATION** (e.g. wheelchair user, communication difficulties/learning disabilities, carers and any other relevant information)

**REFERRERS NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **REFERRERS TITLE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **BASE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CONTACT NUMBER**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE 28.01.19REFERREFERRAL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_