**Hull & East Riding Nutrition and Dietetics**

**REFERRAL FORM**

**\*Please Note: Incomplete forms will be returned, resulting on delayed assessment\***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Referrer: | | | | | | | Date of Referral: |
| Job Title: | | | | | | | |
| Address & contact number/email: | | | | | | | |
| **PATIENT DETAILS** | | | | | | | |
| Registered GP: | | | | | GP Practice Address: | | |
| Title: | Forename: | | | | Surname: | Known as: | |
| Date of Birth: | | | | | NHS Number: | | |
| Gender: | | | | | Ethnicity: | | |
| Address: | | | | | | | |
| Patient Home Telephone Number: | | | | | Patient Mobile Number: | | |
| Preferred contact number: Home  Mobile | | | | | Email address: | | |
| Name of Carer/Parent: | | | | | Contact number of Carer/Parent: | | |
| Consent to contact via SMS: | | | | | Yes | | No |
| Consent to contact via Email: | | | | | Yes | | No |
| Consent to share medical information: | | | | | Yes | | No |
| Translator required: | | Yes | | | No | | Language required\*: |
| Accessible information needs: | | Yes | | | No | | Detail needs: |
| Diagnosis: | | Client aware of diagnosis? | | | Yes | | No |
| Under the care of a consultant (please provide details if known): | | | | | Yes | | No |
| Are there any other services involved in patient’s care? | | | Yes | | No | | Don’t know |
| **(If yes give details)** | | | | | | | |
| **SUPPORTING INFORMATION** | | | | | | | |
| Is there a Lone working risk? | | | | Yes | | | No |
| Is there a Safeguarding risk? | | | | Yes | | | No |
| Has the patient given consent for the referral? | | | | Yes | | | No |
| Any concerns re Mental Capacity? | | | | Yes | | | No |
| **ReSPECT** document in place? | | | | Yes | | | No |
| **(If yes give details)** | | | | | | | |
| **ESSENTIAL INFORMATION** | | | | | | | |
| **Date Measured:** | | | | | | | |
| Height: (metres) | | | | | | | |
| Weight: (kg) | | | | | | | |
| BMI: | | | | | | | |
| MUST Score: | | | | | | | |
| **Other:** | | | | | | | |
| Can patient weight bear? | | | | Yes | | | No |
| **Health Visiting (children):** | | | | | | | |
| Universal: | | | | Yes | | | No |
| Universal Plus: | | | | Yes | | | No |
| Partnership Plus: | | | | Yes | | | No |
| **For Care Homes:**  Has Food First Initiative been commenced: | | | | Yes | | | No |
| If **Yes** please provide evidence: | | | | | | | |
| **MEDICAL HISTORY** | | | | | | | |
|  | | | | | | | |
| **SOCIAL INFORMATION** | | | | | | | |
|  | | | | | | | |
| **REASON FOR REFERRAL** | | | | | | | |
|  | | | | | | | |

**To make a referral please send via email to:** [**chcp.247111@nhs.net**](mailto:CHCP.247111@nhs.net) **or contact Tel – 01482 247111**

\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***