Hospice Dietitian Referral Form

**Please consider whether referral is appropriate in light of disease burden and prognosis, consider what is to be achieved by dietetic assessment**

**Palliative care diet sheets aimed at patients and their carers are available here;** <https://www.wsh.nhs.uk/CMS-Documents/Patient-leaflets/NutritionandDieteticService/6642-1-Eating-and-drinking-when-unwell.pdf>

<https://www.wsh.nhs.uk/CMS-Documents/Patient-leaflets/NutritionandDieteticService/6643-1-When-food-becomes-difficult.pdf>

Supplement drinks are to be recommended only by a dietitian if deemed appropriate after dietetic assessment and the implementation of ‘food first’ advice. Please do not mention or suggest these to the patient.

*Following nutritional screening using MUST and/or request for dietetic consultation*

Inappropriate and/or incomplete referrals will be sent back to the referrer

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| **Patient details:**Name: .....……………………............................................ Date of Birth: ...…………………………NHS No: ………………………………… Current Place of Residence: ………………………………Address: ...................................................................................... Tel No: ………………..…………GP Name/Surgery: ………………………………………………… Tel No: ...................…………….. |
| **Referrer details:**Referred by: ………………………………… Job Title: …………………………………………...Telephone No: ……………………… Location/address:………………………………………...…Signed: …………………………….....…. Date: ….........………… |
| **Reason for referral** (please specify below) please tick boxes: 🞏 Urgent 🞏 Routine …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………Is patient aware of referral? 🞏 Yes 🞏 No **Please consider whether referral is appropriate in light of disease burden and prognosis, consider what is to be achieved by dietetic assessment.**Estimated prognosis (please specify if known): …………………………………………………………. |
| **Diagnosis / Background:** …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………Current medications: ………………………………………………………………………………………..…………………………………………………………………………………………………………………. |
| **Action already taken:**🞏 Homemade/ shop bought nourishing drinks encouraged 🞏 Food fortification advice given🞏 Extra snacks recommended 🞏 Diet sheets given🞏 Patient has already tried: ……………………………………………………………………………  |
| **MUST screening results**  |
| **Step 1**Current weight \_\_\_\_kgHeight \_\_\_\_mBMI \_\_\_\_kg/m2Score \_\_\_\_ | **Step 2**Weight loss over past 3-6 months \_\_\_\_kg% weight loss \_\_\_\_Score \_\_\_\_ | **Step 3**Acute disease effect score \_\_\_\_(Only if acutely ill **and** has had or is likely to have no nutritional intake for >5 days. **Score 2**.) | **Step 4**Overall MUST score (sum of scores from step 1, 2 and 3) \_\_\_\_ |
| **HOW TO REFER – by post or email only** Community Dietetic Service Tel: 01284 713668Maple House email: communitydietitians@wsh.nhs.uk24 Hillside Business ParkBury St EdmundsIP32 7EA |