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 \_\_\_\_kg  Height \_\_\_\_m BMI \_\_\_\_kg/m2  Score \_\_\_\_ | **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 713668  Maple House email: communitydietitians@wsh.nhs.uk  24 Hillside Business Park  Bury St Edmunds  IP32 7EA | | | |