**Referral to Dietitian:**

**Community Dietitian Diabetes Dietitian**

**Date:** \_\_\_\_\_\_\_\_\_\_\_ Patient is able to attend clinic House bound

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Title: Mr/Mrs/Ms/Dr/Other: | | | Address: Home Full Address (single line) | |
| Name: Given Name Surname | | |
| Date of Birth: Date of Birth | | Male/Female | GP: Registered GP Full Address (single line) | |
| NHS Number: NHS Number | | |
| Telephone number (including mobile if known): | | | Next of kin or other contact details if applicable: | |
| Ethnicity & Religion: Ethnic Origin | | | Language spoken: Main Language | |
| Is the patient or carer likely to cause a risk to staff safety? No known risk / Yes (Please specify): | | | | |
| **Clinical Details:** | | | | |
| Current problem / diagnosis: | | Past Medical History: | | |
| Medications: | | | | |
| Relevant blood results: | | | | |
| **Nutritional Details:** | | | | |
| Reason for referral (e.g. unintentional weight loss, obesity, poor diabetic control). Please provide as much detail as possible: | | | | |
| Height:  Weight:  BMI: | | Weight History:  MUST Score: | | |
| Any other relevant information (e.g. communication, social, SLT input, mobility): | | | | |
| **Referrer’s Details:** | | | | |
| Name: | | Address: | | |
| Designation: | |
| Telephone Number: | |
| **Completed form to be sent via fax or email:**  **Telephone: 01704 387262 Fax: 01704 387674**  [**Southport&Formby.SPA@merseycare.nhs.uk**](mailto:Southport&Formby.SPA@merseycare.nhs.uk)  **mcn-tr.southportandformbyspoa@nhs.net**  **Address: Single Point of Access, 5 Curzon Rd, Southport, PR8 6PL** | | | | |