**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****mcn-tr.southportandformbyspoa@nhs.net****Address: Single Point of Access, 5 Curzon Rd, Southport, PR8 6PL** |