

Department of Nutrition and Dietetics

Bassetlaw Community Referral

Please provide a copy of a 4 day food chart - any referrals sent without this information will be rejected

Resident's Name:	DOB:
Address:	Name & designation of person completing form:
Phone Number:	Date:

SECTION 1 - Reason For Referral

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SECTION 2 - Medical History (tick all as appropriate and provide details where possible)

<input type="checkbox"/>	Mental Health Problems e.g. Alzheimer's/Dementia	
<input type="checkbox"/>	Coronary Heart Disease e.g. angina, stroke, heart failure	
<input type="checkbox"/>	Diabetes Type 1 or Type 2	
<input type="checkbox"/>	Neurological Condition e.g. Parkinson's or similar	
<input type="checkbox"/>	Bone Condition e.g. arthritis/osteoporosis	
<input type="checkbox"/>	Lung Condition e.g. COPD or Fibrosis	
<input type="checkbox"/>	Renal Problems	
<input type="checkbox"/>	Swallowing Problems Due to clinical condition e.g. stroke or cancer	
<input type="checkbox"/>	Gut Problems e.g. angina, stroke, heart failure	
<input type="checkbox"/>	Coronary Heart Disease e.g. IBS, Diverticulitis, Crohns etc	
<input type="checkbox"/>	Any other not listed (state)	

SECTION 3 - Weight History (Provide details of weight for the past 3 months)

Date	Weight (kg)	BMI kg/m ²	MUST Score

SECTION 4 - Nutrition Related History

Dietary Intake

Tick all applicable

Current diet provided:

- | | |
|--|---|
| <input type="checkbox"/> Normal diet | |
| <input type="checkbox"/> Enriched diet | |
| <input type="checkbox"/> Texture modified diet: | <input type="checkbox"/> Thickened Fluids: |
| <input type="checkbox"/> Level 7 (Regular) | <input type="checkbox"/> Level 0 (Thin) |
| <input type="checkbox"/> Level 6 (Soft & Bite sized) | <input type="checkbox"/> Level 1 (Slightly Thick) |
| <input type="checkbox"/> Level 5 (Minced & Moist) | <input type="checkbox"/> Level 2 (Mildly Thick) |
| <input type="checkbox"/> Level 4 (Pureed) | <input type="checkbox"/> Level 3 (Moderately Thick) |
| <input type="checkbox"/> Level 3 (Liquidised) | <input type="checkbox"/> Level 4 (Extremely thick) |

Speech & Language Therapy input: YES NO

Thickener used (specify type):

Any other diet - e.g. diabetic (State):

Oral nutritional supplements (ONS):

- GP/nurse has prescribed supplements
- None prescribed
- Homemade Supplements

Level of assistance required at meal times:

- Independent feeder
- Partial assistance required
- Full assistance

Adaptive aids if used:

Please complete all sections email to: dbh-tr.Dietetics@nhs.net

or send to:

Dietetics Administration, Clinical therapies
Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT

Tel: 01302 642742 or 01909 572773

PLEASE NOTE: Incomplete forms will be returned