**Acute Services**

**North Sector**

NHS Greater Glasgow and Clyde

## Patient Referral to Nutrition and Dietetic Service

*All Fields are mandatory, however if any of the requested information is not available please either indicate reason or contact the service to discuss before referring*

| | |
|---|---|
| **Date:** | **Appointment Category**: **routine ☐ or urgent ☐**<br>*see referral guidance for definition of urgent patient* |
| **Patient Name:**<br><br>**Address:** | **Appointment Type**:<br>**out-patient ☐ *housebound patient ☐**<br>*If patient is housebound is there any lone working risk when visiting at home?<br>**Yes ☐ No ☐ Not Known ☐**<br>If 'Yes', give details : |
| **Postcode:** | |
| **10 digit CHI Number:**<br>*This can be obtained from GP or Hospital notes and must be included in referral* | **Patient Telephone Number:** |
| **Referrer Name:**<br><br>**Address:**<br><br>**Postcode:**<br><br>**Telephone Number:** | **GP Name:**<br><br>**Address:**<br><br>**Postcode:**<br><br>**Telephone Number:** |
| **Designation/ Job title:** | **Referrer's Signature:** |

**Do you require notification that the service have received and accepted this referral? Yes ☐ No ☐**

**Diagnosis and Reason for Referral**

| **Height:** | **Weight:** | **BMI:** | **MUST Score:** (for those at risk of malnutrition) | **Date:** |
|---|---|---|---|---|

**Details of any 1st line advice or intervention already carried out: -** Please include information such as date discussed, dietary advice leaflets issued and agreed goals. If no 1st line advice given, please state reason:

**Previous medical and weight history:**

**Current medical treatment and medication, including Oral Nutrition Supplements:**

**Relevant blood results, please include dates:**
*See referral guidance*

**Any additional relevant information e.g. social factors, psychiatric or mental health issues,**