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**Community Dietitian Paediatric Referral Form**

**Please complete ALL fields and return to the Berkshire Health Hub**

[**integratedhub@berkshire.nhs.uk**](mailto:integratedhub@berkshire.nhs.uk) **Tel 0300 3651234 / Fax 0300 3650400**

**If complex learning needs OR if attending a special needs school, please refer to CYPIT**

**Please note incomplete referral forms will not be accepted and will be returned**

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| --- | --- | --- |
| Name of patient:  D.O.B: | NHS Number: | Referral date: |
| Has parent/carer/guardian consented to the referral?  Yes  No  Best interest | Name of person making referral:  Contact telephone number:  Job title/Department/Location: | |
| Ethnicity:  Main language:  Interpreter needed? Yes  No |
| Patient address:  Postcode: | GP name/surgery:  Address  Postcode:  Telephone: | |
| Name of parent/carer or guardian:  Address: (If different from patient)  Telephone number/s: | **Preferred appointment method:**  Face to face (clinic)  Telephone  Virtual appointment  Group workshop – Cows’ Milk Protein Allergy for under 12 months | |
| **Medical Conditions / Relevant medical history / Bloods or test results** (If allergies, please include an allergy focused history) | | |
| **Medication (please include any current prescription of formula milk, ONS etc):** | | |
| **Date**:\_\_\_\_\_\_\_\_\_\_\_    **Weight (kg) & centile:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Height & centile**:\_\_\_\_\_\_\_\_\_\_\_\_\_        ­­­­­­­­­  **Previous weight or centile history if known (include dates):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **REASON FOR REFERRAL** (attach additional information if necessary) | | |
| ☐ Faltering Growth (weight/height <0.4th centile **or** weight crossing down 2 or > Centiles, **or** > 2+ centile difference with weight and height/length)  ☐ Fussy eating/restrictive eating (excluding eating disorders)  ☐ Coeliac disease  ☐ Cow’s Milk Protein Allergy / Multiple allergies  For Non-IgE / Delayed CMPA (mild to moderate), indicate if diagnosis has been confirmed through a 2 week dairy elimination diet, followed by a re-introduction period (See BSACI or NICE Guidelines 116):  ☐ **Yes** or ☐ **No**  ☐ Other (please state)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  We are unable to accept requests for scientifically unsupported diet approaches  **Exclusions:**   * We are not commissioned for paediatric weight reducing services. There are a range of community services to refer into in See Lets get going: [www.lets-get-going.co.uk/referralform](http://www.lets-get-going.co.uk/referralform) available in Reading, Newbury and Slough. * For clients at a special school, complex learning needs or tube fed, refer to CYPIT. * For eating disorders, please refer to Berkshire Eating Disorder Service (BEDS) via CYPF. | | |
| **Other presenting symptoms/further information** (if applicable)  ☐ Reflux  ☐ Constipation  ☐ Diarrhoea  ☐ Failure to thrive  ☐ Nutritional support  ☐ Nutritional deficiencies (ie iron, Vitamin D etc) | | |
| **Other services referred to/involved in clients care** (tick as appropriate):  OT  SLT  CAMHS  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **If referred by out of area specialist hospital/or service please attach medical history/hospital summaries** | | |