NHS
Berkshire Healthcare
NHS Foundation Trust

Community Dietitian Nursing Home Referral Form

Please complete ALL fields.
Incomplete referral forms will be returned to sender and the referral will not be accepted.
Once complete please return to the Berkshire Health Hub
Email integratedhub@berkshire.nhs.uk Call 0300 365 1234

<table>
<tr><td>NHS Number (1 digit per box please)
☐☐☐☐☐☐☐☐☐☐</td><td>Referrer Name & Job Title:

Referrer Contact No:</td></tr>
<tr><td>Date of referral:

Patient Name:

Patient Address:

Patient Contact No:
Home:
Mobile:

GP Name:

Ethnicity:

Date of Birth:</td><td><u>Mental Capacity</u>
Is the patient able to consent to treatment?
YES ☐ NO ☐

If NO, please give details of Health & Welfare LPA (Lasting Power of Attorney) holder. If no LPA in place, provide details of Next of Kin:
Name:
Relationship: LPA Holder ☐ Next of Kin ☐
Contact No:
Address:
Email:
If Health & Welfare LPA in place, please include a photocopy of the agreement.
Health & Welfare LPA photocopy included? ☐</td></tr>
<tr><td><u>Past Medical History</u></td><td><u>Medications</u></td></tr>
<tr><td colspan="2"><u>End of Life</u>
Is this patient receiving End of Life Care? YES NO

Has the GP stopped patients' medications? YES NO</td></tr>
<tr><td colspan="2"><u>Swallowing texture</u> (as recommended by a Speech and Language Therapist)

Food texture: No modifications (Level 7) ☐ Soft & Bitesize (Level 6) ☐ Minced & Moist (Level 5) ☐ Puree (Level 4) ☐ Liquidised (Level 3) ☐

Fluid thickness: Thin (Level 0) ☐ Slightly thick (Level 1) ☐ Mildly thick (Level 2) ☐ Moderately thick (Level 3) ☐ Extremely thick (Level 4) ☐

Do you have any concerns with patient's swallowing?* YES ☐ NO ☐

Have there been any choking or coughing episodes after eating or drinking?* YES ☐ NO ☐
(*If answered yes, please refer to Speech and Language Therapy)</td></tr>
</table>

NHS Number (1 digit per box)	**Patient Name:**

<u>Blood test results</u>

Are there any blood test results relevant to the referral e.g. lipids, blood sugars? Please state results here.

<u>Please state reason for referral to Nutrition and Dietetics Service:</u>

<u>What specific achievable aim are you seeking from Dietetic support?</u>

<u>Current weight/height</u>	**<u>Weight history</u>**
Weight (kg):	**Weight 3 months ago (kg):**
Height (m):	**Weight 6 months ago (kg):**
BMI (kg/m^2):	**Weight loss (kg) and (%):**
If unable to weigh, please supply a MUAC (cm):	

<u>Malnutrition risk</u>

Only MUST <u>score of 2</u> or above will be accepted by department for advice

MUST score for BMI: 0 ☐ 1 ☐ 2 ☐ **MUST score for weight loss:** 0 ☐ 1 ☐ 2 ☐

OVERALL MUST score: 0 ☐ 1 ☐ 2 ☐ Above 2 ☐

Please use www.bapen.org.uk/screening-and-must/must-calculator to calculate MUST score

COVID-19 nutrition rehab i.e. weight loss and/or muscle weakness YES ☐ NO

Following ICU stay? Yes ☐ No ☐

How long has the patient had this MUST score?

Are you currently following any MUST action plan? YES ☐ NO ☐

If YES please provide details:

Is patient on oral nutritional supplements? YES ☐ NO ☐

If YES please state:

Does this patient have a pressure ulcer? YES ☐ NO ☐

If YES please grade:

Thank you for completing this referral form, please remember to return the completed form to the Referral Hub by email to **integratedhub@berkshire.nhs.uk** OR Referrals can also be made via the HUB by phone 0300 365 1234

Also, **incomplete referral forms will be returned to sender and the referral will not be accepted.**