Nutrition and Dietetic Service
Community Referral Form

NHS East Lancashire Hospitals NHS Trust

Please fill out the form giving as many details as possible
INCORRECT FORMS WILL BE RETURNED TO THE REFERRER

1. PERSONAL DETAILS			
Name:		NHS number:	
Address:			
Postcode:		Date of Birth:	
Home No:		Work No:	Mobile No:

2. GP DETAILS		
GP Name / Practice:		Tel No:

3. DIAGNOSIS / REASON FOR REFERRAL

If other is chosen please state diagnosis:

REASON FOR REFERRAL	**MEDICAL CONDITIONS / INVESTIGATIONS / MEDICATION**

Weight(Kg)	Height(m)	BMI(Kg/m2)	% Weight loss	MUST score

4. ADDITIONAL INFORMATION

Are there any safety/security issues involved in seeing this patient No Yes

* *If yes specify reason:*

Interepreter required No Yes

* *If yes specify language:*

5. REFERRER DETAILS

Name: Position:

Contact No: Date:

This referral has been agreed with the patient: Yes No Implied

Email to: dietitians@elht.nhs.uk

Safe | Personal | Effective