**Nutrition and Dietetic Service**

**Community Paediatric Referral Form**

Please fill out the form giving as many details as possible

\*INCORRECT FORMS WILL BE RETURNED TO THE REFERRER\*

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| **1. PERSONAL DETAILS** |
| Name of child: | Click here to enter name | NHS number:Click here to enter NHS number |
| Name of Parent or guardian: |  |
| Home Address: | Click here to enter address |
| Postcode: | Click here to enter postcode | Date of Birth:Click here to enter DOB. |
| Home No: Enter number | Work No: Enter number | Mobile No: Enter number |
| **2. GP DETAILS** |
| GP Name: | Click here to enter GP name. | Tel No: Enter GP number. |
| **3. DIAGNOSIS / REASON FOR REFERRAL** |
| **Please choose from list** | **See referral criteria for further information.****If other is chosen please state diagnosis:** State diagnosis if other chosen. |

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| **Weight & Height history and additional referral information:** |
| **Current Weight(Kg)** | **Weight centile** | **Height(cm)** | **Height centile** | **BMI (kg/m2)** | **BMI centile** |
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| **4. ADDITIONAL INFORMATION** |
| Are there any safety/security or safeguarding issues involved in seeing this patient [ ]  No [ ]  Yes \* *If yes specify reason:*  Specify reason |
| Interpreter required [ ]  No [ ]  Yes \* *If yes specify language:*  Specify language required |

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| **5. REFERRER DETAILS** |
| Name: Enter name. Position: Enter position.Contact No: Enter contact number Date: Click here to enter a date. |
| This referral has been agreed with the patient: Yes [ ]  No [ ]  Implied [ ]  |
| **Email to:** dietitians@elht.nhs.uk |