**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](mailto:dietitians@elht.nhs.uk) |