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| **REFERRAL TO QMH OUTPATIENTS DIETITIAN - ADULTS**Incomplete or illegible referral forms will not be accepted and will be returned to the referrer. |
| HAS THIS REFERRAL BEEN AGREED WITH THE PATIENT? YES/NO**DOES THIS PATIENT REQUIRE HOSPITAL TRANSPORT? YES/NO**IS THIS PATIENT HOUSEBOUND THEREFORE REQUIRING A HOME VISIT? YES/NO**DOES THIS PATIENT HAVE A DISABILITY? YES/NO: Details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| DATE OF REFERRAL: |
| NAME, POSITION, ADDRESS AND TELEPHONE NUMBER OF REFERRER: |
| SURNAME:SEX:D.O.B. | FORENAME:MARITAL STATUS:ETHNIC ORIGIN: |
| NHS No: |  |  |  |  |  |  |  |  |  |  |
| ADDRESS:POSTCODE: | DAY TIME TELEPHONE No:MOBILE No: |
| EMAIL ADDRESS: |
| DIAGNOSIS AND DATE: |
| **REASON FOR REFERRAL:** |
| Information essential for referrals for **weight management, Diabetes and CHD** *(Can attach EMIS printout):*Total Chol: HDL Chol: LDL Chol:HbA1C: Blood Pressure:Is the patient able to take part in physical activity/ exercise?: Y/N |
| **GROUP EDUCATION** Is this patient suitable for group education? Y/NType 2 Diabetes (**If patient has been diagnosed with Type 2 diabetes for less than 12 months refer to DESMOND)**Weight management  |
| **WEIGHT:** | **HEIGHT:** | **BMI:** | **Waist: circumference** | **\*MUST Tool Score:** |
| DRUG THERAPIES*(Can attach EMIS printout)*: |
| OTHER RELEVANT CLINICAL/SOCIAL DETAILS:Interpreter required? Yes/no Language: |
| GP DETAILS |
| NAME:ADDRESS:POSTCODE: | SEND TO: Nutrition & Dietetic Service, **Community Services Division,** **Queen Mary’s Hospital, Roehampton Lane,**  **London, SW15 5PN.** cswdietitians@nhs.net **Telephone: 020 8487 6629**  |

**NB Referrals for malnutrition/nutrition support require a MUST Score**

**(see overleaf for St George’s NHS Health Trust MUST Tool and Nutrition Care Pathway)**.

**Referrals for patients with Eating Disorders are not accepted.**

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