Referrer (print full name): ………………………….…… Job title: ………………………………..….

Tel No: ………..…………………………….................... Location: …………………………..………

Signed: …………………………..…………………….….. Date: …………………………………….…

Please send the completed referral form and any attachments to University Hospitals Sussex Dietitians at:

**St Richard’s Hospital:** **uhsussex.chichesterdietitians@nhs.net**

**Worthing Hospital:**  **uhsussex.whdietadmin@nhs.net** *Dietitians Referral Form - Adults*

**For patients with ‘MUST’ score of ≥2 (high risk of malnutrition) confirm the following actions have been completed:**

□ Underlying cause(s) of malnutrition considered and addressed (provide details above)

□ ‘Eat Better, Feel Better’ leaflet provided and discussed on date: .………….

□ One month trial of oral nutritional supplements in line with formulary commenced on date: ………….

Details: …………………………………………………………………………………………………………………..

Current Speech & Language Therapy Input? Yes / No Any swallowing difficulties identified? Yes / No

Diet: Regular (IDDSI 7) / Soft & Bite Sized (IDDSI 6) / Minced & Moist (IDDSI 5) / Pureed (IDDSI 4) / Liquidised (IDDSI 3)

Fluids: Thin (IDDSI 0) / Slightly thick (IDDSI 1) / Mildly Thick (IDDSI 2) / Moderately Thick (IDDSI 3) / Extremely Thick (IDDSI 4)

**Weight history/weight 3-6 months ago** (attach weight/’MUST’ form if available):

**Current Anthropometry:**

Date: ……………… Weight: ................ Height: ................. BMI: ................. ‘MUST’ Score: ......................

Alternative measurements e.g. MUAC (if required): …………………………………………………………………

Please inform us of any changes in clinical condition which may affect the urgency or appropriateness of referral.

**Reason for referral:**

Name: ……………………………………............................... Date of Birth: .…………………………………..

Address: …………………………………………………………………………………………………………………..

……………………………………………………………………… Tel No: ………………………………………….

GP: ………………………………….. Hospital No: …………………….. NHS No: …………..........................

Medical History (or attach summary sheet): .......................................................................................................

………………………………………………………………………………………………..……………………………

Current Medication (or attach summary sheet): ..............................................................................................

…………………………………………………………………………………………………………………………...…

Other relevant information e.g. carer details, underlying causes for malnutrition: ………………………………

…………………………………………………………………………………………………………………........................................................………………………………………………………………………………………………………………………………………………………………………………………………………………………………...………………………

Has this referral been agreed with the patient (or relative/carer if lacks capacity) o

Is the patient housebound? Yes o No o If a home visit is required, any risks identified? Yes o No o

If yes, please specify risk identified: ………………………………………………………………………………….