Adult Referral Form – Sheffield Community Dietetics Service

Send to Department of Community Dietetics, Manor Clinic, 18 Ridgeway Road, S12 2ST
Email: sht-tr.CommunityDietitians@nhs.net Fax: 0114 3078439
Queries can be made to: 0114 3078440 **PLEASE SHARE THE PATIENT RECORD**

Surname Mr/Mrs/Miss/Other	First Name
Address Post code	GP Practice Address Post Code
Date of Birth: Patients can be adults of any age	GP Telephone:
Telephone No:	GP Fax:
NHS No:	Ethnicity*
Gender: M F Civil Status: M S W D	Pregnant: Yes □ No □ EDD -----/-----/-------

Reason for referral: Sheffield Community Dietetics service is able to see all community diet therapy referrals who have a Sheffield GP and meet our referral criteria guidelines.
Please tick a box below and clarify your reason for referral in the space provided.

Height | Weight | BMI

Referral Criteria:

- □ Type II Diabetes
- □ Impaired Glucose Tolerance
- □ Nutrition Support
- □ Neurological conditions/dysphagia
- □ Modified texture diet (after assessment by SLT)
- □ Food allergy/intolerance
- □ Eating disorder/disordered relationship with food
- □ CVD risk factors
- □ Coeliac Disease
- □ Gluten sensitivity
- □ Diverticular Disease
- □ IBS (FBC, ESR, CRP, EMA results required)
- □ IBD
- □ Other GI conditions
- □ Renal stage 1-3
- □ Vitamin/mineral deficiency
- □ PCOS

Further details- specifically why is Dietetic treatment required? What outcome is required?

Past medical history - please list or attach summary

Social circumstances

Has first line dietary advice been given? Yes □ No □

Medication – please list or attach current medication summary

Relevant recent measurements (e.g. BP, HbA1c, lipids)

Please note all the above fields are mandatory - incomplete forms will be returned.

Other services involved (e.g. District Nurse, CPN, Health Visitor, CCN, Hospital Services/Consultant etc.)	
Are there any safety/security issues involved in seeing this client? No □ Yes □ If yes, what?	
Is an interpreter required? No □ Yes □ What language? (Service will arrange directly)	
Referred by: Name (please print) Signature Date of referral Designation (if not GP)	Address of Referrer:
This referral has been agreed with the patient : Yes □ No □	

***Ethnic Categories**

- **White**
  - British — A
  - Irish — B
  - Any other White background — C
- **Mixed**
  - White and Black Caribbean — D
  - White and Black African — E
  - White and Asian — F
  - Any other mixed background — G
- **Asian or Asian British**
  - Indian — H
  - Pakistani — J
  - Bangladeshi — K
  - Any other Asian background — L
- **Black or Black British**
  - Caribbean — M
  - African — N
  - Any other Black background — P
- **Other Ethnic Groups**
  - Chinese — R
  - Any other ethnic group — S
- **Not Stated**
  - Not stated — Z

An electronic copy of this referral form is available at
https://sites.google.com/site/sheffieldccgportal/

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