**Paediatric Dietetic Referral Form**

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| Please complete this form fully and return to:  **Paediatric Dietitians, Nutrition & Dietetic Department,**  **The Great Western Hospital, Marlborough Road, Swindon, SN3 6BB**  or email it to: [**gwh.paediatricdieteticreferrals@nhs.net**](mailto:gwh.paediatricdieteticreferrals@nhs.net)  Please note that this email address is for referrals only.  If the referral is urgent please telephone the Dietetic  Department on 01793 605145.  ***Please note that incomplete forms may be returned***. | For official use only   |  |  |  | | --- | --- | --- | | **Date Rec** | | Click here to enter a date. | | **Triage** | **GWH** | Choose an item. | | **Community** | Choose an item. | | **CMPA Group** | Choose an item. | | **Reject** |  | | **Tick if urgent** |  | | Date of appointment | | Click here to enter a date. | | Previously seen/ NRC? | |  | |

**Patient Details**

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| **Patient Name**: Click here to enter text.  **Date of Birth:** Click here to enter a date.  **NHS number:** Click here to enter text.  **Gender at birth:**  Choose an item. | **Address:** Click here to enter text.  **Contact no:** Click here to enter text.  **Does patient consent to message being left on answer phone?** Yes  No  **Does patient consent to text message correspondence?**  Yes  No |

**GP and Next of Kin Details**

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| **GP Name:** Click here to enter text.  **GP Practice address:** Click here to enter text.  **Postcode:** Click here to enter text.  **Tel number:** Click here to enter text. | **Next of Kin Name:** Click here to enter text.  **Relationship to patient:** Click here to enter text.  **Telephone number**:Click here to enter text.  **Are they the main carer?** Yes  No  **If no, does the patient have another carer?** Yes  No  **Please provide contact name and details:**  Click here to enter text. |

**Referral Details**

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| **Is an interpreter required?** Yes  No  N/A  Details: Click here to enter text.  **Are there any safeguarding issues relating to patient?**  Yes  No  N/A  Details: Click here to enter text.  **Does the patient have any difficulties with mobility?** Yes  No  N/A  Details: Click here to enter text.  **Please indicate other services involved:** Click here to enter text.  **Any other relevant information:** Click here to enter text. |

**Medical Information**

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| **Diagnosis:** Click here to enter text.  **Past Medical History:** Click here to enter text.  **Does the patient have any allergies or intolerances?**  Yes  No  Details: Click here to enter text.  **Weight:** Click here to enter text. **Height:** Click here to enter text.  **Other comments:**  Click here to enter text. |

**Reason for Referral**

Please indicate reason for referral below (to the left).

Additional information has been provided (on the right): These actions are optional to assist you and/or the patient in the interim (not all actions may be relevant to your role). Please indicate any points that are actioned.

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| **Reason(s) for referral** | **Educational checklist** |

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|  | **Mild to moderate** IgE or Non-IgE Cow’s milk protein allergy (CMPA)  **Severe** IgE or Non IgE mediated CMPA please also refer to the GWH Paediatricians  **Allergy focussed history questions at the end of this form are required for this referral and your form may be returned if these questions are not completed.** | Refer to BSW CMPA guideline  <https://prescribing.bswccg.nhs.uk/?wpdmdl=6681>  As per the guideline, a milk-free diet must have been commenced in primary care, and a milk-challenge completed for suspected non-IgE CMPA, prior to referral to dietetics. |  |
|  | Other single food allergy (e.g. soya or egg or wheat or nut)  Children with IgE or multiple food allergies - please also refer to the GWH Paediatricians | Provide link to the Allergy UK advice on food allergies  <https://www.allergyuk.org/information-and-advice/conditions-and-symptoms/36-types-of-food-allergy> |  |

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|  | Faltering growth **(INFANTS – up to 2 years of age)**  Weight and length MUST be included with the referral |  |  |
|  | Faltering growth **(CHILDREN)**  Weight and height MUST be included with the referral | Provide first line advice on food fortification and energy dense foods Recommend milky drinks and nourishing snacks between meals |  |
| For 2-5 year olds: Provide link to NHS underweight advice  <https://www.nhs.uk/live-well/healthy-weight/underweight-children-2-5-advice-for-parents/> |  |
| For 6-12 year olds: Provide link to NHS underweight advice  <https://www.nhs.uk/live-well/healthy-weight/underweight-children-6-12-advice-for-parents/> |  |
|  | Suspected Eating Disorders | Refer to CaMHS  <https://www.oxfordhealth.nhs.uk/camhs/refer/> |  |
|  | Functional GI disorders  (e.g. IBS)  TTG: Click here to enter text.  **Specify:**  Click here to enter text. | Check TTG negative (on gluten containing diet) to rule out coeliac disease NB Gluten should be consumed in more than one meal every day for at least 6 weeks before testing |  |
| Provide BDA Food Fact Sheet on Irritable Bowel Syndrome <https://www.bda.uk.com/foodfacts/IBSfoodfacts.pdf> |  |
|  | Coeliac disease  TTG: Click here to enter text. | Signpost to Coeliac UK website. Recommend membership. <https://www.coeliac.org.uk/home/> |  |
| Provide link to relevant webinar:   * Newly Diagnosed Coeliac Disease / Review for Coeliac Disease * Calcium and Coeliac Disease   <https://patientwebinars.co.uk/coeliac/webinars/> |  |

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|  | **Other: (please state)**  Click here to enter text. |

**PLEASE NOTE WE DO NOT ACCEPT REFERRALS FOR THE FOLLOWING**

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|  | Lactose intolerance | Refer to the NHS advice on common conditions in children  <https://www.nhs.uk/common-health-questions/childrens-health/what-should-i-do-if-i-think-my-baby-is-allergic-or-intolerant-to-cows-milk/> |  |
|  | Toddler diarrhoea | Provide link <https://patient.info/childrens-health/acute-diarrhoea-in-children/toddlers-diarrhoea> |  |
|  | Constipation | Please follow the NICE guidelines and provide link <https://www.nhs.uk/conditions/constipation/> |  |
|  | Nutritional deficiency, eg. Iron, calcium | Provide BDA Food Fact Sheet on specific nutrients in food  <https://www.bda.uk.com/foodfacts/home> |  |
|  | Weaning | Provide link to the NHS weaning advice <https://www.nhs.uk/start4life/weaning/> |  |
|  | Healthy eating advice | Provide link to NHS Change4Life and Eatwell information:  <https://www.nhs.uk/change4life>  <https://www.nhs.uk/live-well/eat-well/> |  |
|  | Weight management | Provide link to NHS Weight Management Advice for Children <https://www.nhs.uk/change4life>  Provide link to First Step Nutrition Eating Well Resources <https://www.firststepsnutrition.org/eating-well-resources>  Provide link to NHS Patient webinar on weight management in children  https://patientwebinars.co.uk/condition/weight-management-in-children/further-information-hand-outs/ |  |
| Consider referral to Healthy Lifestyles Service:  **Swindon**  <https://www.swindon.gov.uk/info/20139/live_well_swindon_hub/923/leading_an_active_lifestyle/2>  **Wiltshire**  <https://www.wiltshire.gov.uk/public-health-weight-management> |  |
|  | Fussy eating/restricted diet  WITHOUT faltering growth | Provide link to the Infant and Toddlers Forum advice on fussy eating  <https://infantandtoddlerforum.org/toddlers-to-preschool/fussy-eating/> |  |
| Provide link to the NHS advice on fussy eating  <https://www.nhs.uk/conditions/pregnancy-and-baby/fussy-eaters/> |  |
|  | Extreme selective / restricted eating habits | Provide link to NHS Patient webinar on fussy eating  <https://patientwebinars.co.uk/condition/fussy-eating-in-children/webinars/> |  |

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| **Name of referrer:** Click here to enter text. **Signature:** Click here to enter text. **Date:** Click here to enter a date.  **Referrers Profession:** Choose an item.  **Referrer’s address:** Click here to enter text.  **Contact telephone no:** Click here to enter text.  **Email address:** Click here to enter text.  **(please provide contact details as we may need to clarify any information on this form)** |

**Allergy Focused History**

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| **Allergy Focused History** | | | |
| **How old was the infant when the symptoms first appeared? Please describe what happened at this time.** | | | |
| Click here to enter text. | | | |
| **How soon after having cow’s milk (or other food) did symptoms generally appear?** | | | |
| *Please tick one:* | Within 30 minutes | Between 30 minutes and 2 hours | 2-24 hours later |
|  | 24-48 hours later | 48-72 hours later |  |
| **Presenting symptoms and pattern of appearance:** Please tick all relevant sections | | | |
| **Skin:** | Itching  Redness / flushing  Nettle rash  Eczema  Swelling | | |
| **Pattern** | Intermittent **OR**  Continuous | | |
| **Oro-pharyngeal:** | Pruritus  Swelling (lips, tongue, pharynx)  Vocal changes  Throat closure | | |
| **Pattern:** | Intermittent **OR**  Continuous | | |
| **Gastrointestinal:** | Acute abdominal pain  Bloating/excessive wind  Blood or mucous in the stool  Constipation  Diarrhoea/loose frequent stools  Gastro-oesophageal reflux  Back arching  Projectile vomiting | | |
| **Pattern:** | Intermittent **OR**  Continuous | | |
| **Respiratory:** | Runny nose / congestion  Conjunctivitis  Nasal itching  Sneezing  Cough  Wheeze  Shortness of breath | | |
| **Pattern:** | Intermittent **OR**  Continuous | | |
| **Anaphylaxis**: | Severe respiratory symptoms/collapse of circulatory system requiring steroids or adrenaline | | |
| **Other:** | Pallor,  Tiredness,  Faltering growth,  Malnutrition  Other condition: Click here to enter text. | | |
| **Pattern:**  **Family History of Atopy:** | Intermittent **OR**  Continuous  Yes  No | | |