Adult Referral

Leicestershire Nutrition and Dietetic Service

DIETETIC REFERRAL FORM (ADULTS) – PRIMARY HEALTH CARE OUTPATIENTS

Please note this form should be posted or FAXED. Please DO NOT send electronically.

FROM: Name ……………………………………………… Job Title……………………………………………….

Referrers Correspondence Address ………………………………………………………………………………

…………………………………………………….Tel No…………………………….Fax…………………………….

To: Leicestershire Nutrition and Dietetic Service, 11/12 Warren Park Way, Enderby, Leicester LE19 4SA

Fax: 0116 272 7228 **Telephone: 0116 272 7200**

DATE OF REFERRAL:	NHS NO:	PATIENT SURNAME: FORENAME/S:	
GP NAME AND ADDRESS:		PATIENT ADDRESS: POST CODE:	
REGISTERED GP (if different from above)		PT. DAYTIME TEL NO:	DATE OF BIRTH:
SPECIAL REQUESTS: (e.g. Language/interpreter)		SEX: M / F	WEIGHT:
REASON FOR REFERRAL:		BMI:	RECENT BP:
		RELEVANT TEST RESULTS FOR REFERRAL e.g. CHOLESTEROL………………………………………. TRIGLYCERIDE…………………………………….. HBA1c……………………………………………... Other relevant Biochemistry…………………………..	
RELEVANT MEDICATION e.g. for diabetes, weight management, lipid control			
RELEVANT MEDICAL/SOCIAL HISTORY:			
DIET SUGGESTED:		SUGGESTED TREATMENT OPTION: *Please tick most appropriate option* ONE TO ONE ☐ GROUP SESSION ☐ A HOME VISIT IS REQUIRED ☐ patient is unable to travel (please refer to LNDS home visit criteria)	

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INCOMPLETE REFERRALS MAY BE RETURNED

AUGUST 2008