**OUTPATIENT DIETETIC REFERRAL FORM**

NHS Number…………………………………..

Surname……………….……….Title…...........

Forename………………………………………

Address…............................................................................................ Postcode……………

Telephone/mobile………….……………….

Date of Birth…………………..……………….

Sex: M / F

Interpreter required Y / N Language................

GP Name………………………………………

GP Practice……………………………………

Contact number……………………………….

Referrers name / Profession / contact details (if different from GP) ......................................

........................................................................

Consultant Name ………………………………………..

Signature……………………………………….

Date of referral…............................................

Please refer to UHBW Outpatient Nutrition & Dietetic Service [Referral Criteria](https://remedy.bnssgccg.nhs.uk/adults/dietetics-nutrition/local-services/) before completion.

We are primarily a service for referrals generated from secondary care; however we will accept the more highly complex cases that meet the service criteria.

Please complete ALL boxes. Incomplete referrals may be returned to reduce clinical risk.

Reason for referral **(please include as much relevant information as possible attaching additional information as necessary)**

Height Weight BMI

Other relevant medical history

Relevant medications

Relevant biochemistry and/or investigation results for referral **(see referral criteria and attach results if necessary)**

Please send referrals to:

Department of Nutrition and Dietetics, Adult Therapy Department, A804, Queens Building, Bristol Royal Infirmary, Bristol, BS2 8HW or Department of Nutrition and Dietetics, First Floor Dormers Building, Weston General Hospital, Grange Road, Uphill, Weston-Super-Mare, BS23 4TQ

Any additional Information? (i.e. Learning difficulties, mental health issues, other disabilities, social history/issues, safeguarding, other healthcare professional involved)

October 2021

Medical Diagnosis