LAST NAME

Patients First Name

BCH Diabetes & Nutrition Services
REFERRAL FORM B
For Nutrition & Dietetic Referrals Only

Please send to:
Diabetes & Nutrition Services (DANS)
John Milton Clinic
Crow Lane, Henbury, Bristol, BS10 7DP
Tel: 0117 9598970
Fax to: 0117 9598971
Email to:DANS.Bristol@nhs.net

This form should be completed by the referrer. The person you are referring must be informed that their details are being forwarded to the Diabetes & Nutrition team office.

Please use this form for Nutrition & Dietetic referrals only
Please complete with as much detail as possible, including the equality monitoring form.

Date of Referral:	GP's Name:
Referred by:	GP Practice and Address: :
Patients details: **Title**:	NHS Number:
First Name:	Date of Birth:
Last Name:	Male ☐ Female ☐
Address: Postcode: Daytime Phone Number: Mobile Number: Email Address:	**Preferred Contact Options:** (please provide details) ☐ Post ☐ Phone ☐ Text ☐ Email

Relevant test results:		**date taken:**
Fasting blood glucose	mmol/l	
HDL cholesterol	mmol/l	
LDL cholesterol	mmol/l	
Total cholesterol	mmol/l	
Triglycerides	mmol/l	
Other investigations e.g.: coeliac screen		

Relevant test results:		**date taken:**
eGFR	ml/min	
Blood pressure	mmHg	
Weight	kg	
Height	m	
BMI	kg/m^2	
Waist circumference	cm	
Other: (please state)		

Social / Activity levels:	**Special Needs?** e.g. wheelchair access, language interpreter, special diet, hearing loop, learning difficulty etc, ☐ Yes ☐ No **Please Specify:**

Please complete page 2

Referral Details:

Diagnosis: **Date Diagnosed:**	**Treatment(s):**
Other Relevant Medical History: **Any Known Allergies?**	**Other Relevant Medications:** **Other Comments:**

Reason for referral:

NB: Please use this form for Nutrition & Dietetics referrals only. For diabetes referrals please use form A

- ☐ IBS
- ☐ Known Coeliac disease
- ☐ Reduce lipids
- ☐ Nutritional deficiencies (please specify)
- ☐ Reduce weight (must have a co-morbidity)
- ☐ Malnutrition ("MUST" screening tool nutrition risk score ≥ 2)
- ☐ Impaired glucose tolerance
- ☐ Other gastric (please specify)
- ☐ Other (please give details)

Has any dietary information already been given? ☐ Yes ☐ No

Please give details:

For office use only:

If you have any queries, please telephone us on 0117 9598970