**Manchester Community Nutrition Service**

**Nutrition Support Referral Form**

Please note, referrals will only be accepted if the following criteria is met:

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| **Referral criteria**   * Reason for referral is **malnutrition or risk of malnutrition** * MUST score ≥ 2 (For guidance see [www.bapen.org.uk/screening-and-must/must-calculator](http://www.bapen.org.uk/screening-and-must/must-calculator)) and first line actions have been implemented * Patient has consented to this referral, or, if patient does not have capacity the referral is in the patient’s best interests * Patient is ≥18 years old * Resident lives in Manchester and/or is registered with a Manchester GP | **Exclusion criteria**   * Reason for referral is unrelated to malnutrition * Patient is unwilling to make any dietary changes * Patient has a diagnosed or suspected eating disorder * Patient has a swallowing difficulty and has not yet been referred to the speech and language therapy (SALT) service. SALT assessment is required prior to dietetic input * Patient is in the terminal phase of their illness and dietetic intervention may not be appropriate. Discuss concerns with GP and palliative care team * Patient is refusing all food and drink. Seek medical advice |

**Please complete the referral form in FULL, including current weight and weight history. Failure to do so will result in a delay in the patient being seen**

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| **Patient details** | **First name** | | **Surname** |
| **Gender M  F** | **D.O.B** | | **NHS number** |
| **Ethnicity** | | | **Religion** |
| **Address including postcode** | | | **Home phone number** |
| **Mobile number** |
| **Is the patient registered housebound?**  **Yes  NO** |
| **Please detail any security or safeguarding issues we should be aware of for a safe consultation** | | | |
| **Interpreter required? Yes  NO ,** if yes, **which language?** | | | |
| **Does the patient have capacity? Yes  NO** *(If no please specify details of who to contact below)* | | | |
| **Next of kin details** | | | |
| **Reason for referral,** *please provide as much detail as possible e.g. history of problem, any dietary advice provided, any barriers to adequate nutritional intake, any first line actions implemented and any oral nutritional supplements trialled or prescribed etc* | | | |
| **Please confirm GP summary or hospital discharge summary is included with this referral 🞎**  *If these are unavailable, please provide medical history and medications below*. | | | |
| **Medical history** | | **Medications** | |

Oral Nutrition Supplements are in use/ prescribed - **Yes NO**

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| **Please provide details and contact numbers of other services involved** *(e.g. Social services, district nurse, ACM, speech and language therapy (SALT), care agency, CMHT etc)* |
| **Does the patient have any swallowing difficulties Yes NO** *If yes, please refer to SALT* |
| **Social situation** *(e.g. lives alone)* |
| **Learning/Behavioural/Communication difficulties** |

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| **Weight history** | **Height (m)** | **BMI (kg/m2)** | **Current weight (kg)**  **Date taken:** |
| **Previous weights over past 3 – 6 months:**  **Date ……………………………….. Weight (kg)…………………**  **Date ……………………………….. weight (kg) …………………**  **Date ……………………………….. weight (kg) …………………** | | | **MUST score:**  *For guidance please see* [*www.bapen.org.uk/screening-and-must/must-calculator*](http://www.bapen.org.uk/screening-and-must/must-calculator) |
| **Which scales does the patient require?**  standing wheelchair hoist |
| *If it is not possible to obtain, the patient’s height, weight or BMI, please refer to*[*www.bapen.org.uk/screening-and-must/must-calculator*](http://www.bapen.org.uk/screening-and-must/must-calculator) *for guidance on assessing patients nutritional risk using ‘subjective criteria’, including MUAC measurement. Please provide details below.* | | | |

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| **GP details** | **Telephone** | **Fax** |
| **GP address or practice stamp** | | **Email** *(NHS.net preferred)* |

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| **Referrer details** | | **Telephone** | **Fax** |
| **Email address** *(NHS.net preferred)* | | | |
| **Referrer name** | | | **Job title** |
|  | **Please tick to confirm the client/carer has agreed to this referral** | | |
| **Referrer signature Date** | | | |

To make a referral please email the Single Point of Access on [mft.spa-uhsm@nhs.net](mailto:mft.spa-uhsm@nhs.net) or telephone

**0300 303 9650 .** The Single Point of Access is open 7 days a week 8am – 10pm.

To contact the team about a patient query please email [mft.communitynutrition@nhs.net](mailto:mft.communitynutrition@nhs.net).