

Dietitian Referral Form For Nursing Home Residents

Resident Name	
Resident DOB	
Nursing Home name	
Name of referrer and job title	
Date of referral	
Telephone number	
Email address	

Consent Please select as appropriate:	<input type="checkbox"/> The resident has consented to this referral <input type="checkbox"/> The referral has been made in the resident's best interests
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Medical History	
Reason for Dietetic referral	
Current clinical status: acute disease/recent infection etc or clinically stable (please specify)	

Is the resident receiving end of life care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has ceiling of care been discussed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this resident a potential candidate for enteral tube feeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Skin integrity	<input type="checkbox"/> Intact	<input type="checkbox"/> Pressure ulcer*	<input type="checkbox"/> Other*
*Please specify area and grade:			

Current diet and fluid regime

Method of intake:

Oral feeding/drinking

PEG/RIG

PEG/RIG + Oral

Has food intake recently been reduced?

Yes*

No

*If Yes, please supply further details:

Please attach completed food and fluid chart (available @ www.clinicalnutrition.ie) and a current medications list.

Any nausea/vomiting?

Mobility level

Recent abnormal biochemistry

Blood sugars (if applicable)

Bowel motility

Current swallow recommendations

Never previously assessed

If previously assessed: SLT name:

Date:

FOOD	LIQUID
<p>Level 7: Regular</p> <p>Level 7a: Regular Easy to Chew</p> <p>Level 6: Soft and Bite-Sized</p> <p>Level 5: Minced and Moist</p> <p>Level 4: Pureed</p> <p>Level 3: Liquidised</p>	<p>Level 0: Thin</p> <p>Level 1: Slightly Thick</p> <p>Level 2: Mildly Thick</p> <p>Level 3: Moderately Thick</p> <p>Level 4: Extremely Thick</p>

Weight History

Weight History	Weight (kg)	BMI (kg/m ²)	MUST score
Current			
Last month			
3 months ago			
6 months ago			

Dietary requirements:

None

Lactose intolerant

Diabetic

Nut allergy

Fortified diet

Coeliac

Please provide prescribed oral nutrition support (if applicable) and document how much of each they are managing:

If tube feed patient please document feed name, volume, rate and hours of feed:

By sending this referral I understand:

- The resident (or referrer if the resident is unable to give informed consent) understands & acknowledges that their personal information will be securely used, stored and shared in order to provide ongoing clinical care.
- The information obtained by this form will be used for the purposes of therapeutic assessment only and will not be used by any other party. For more information on how we use this data please [click here](#).
- Incomplete referrals will be returned and may delay assessment time.
- Assessments may be carried out remotely or in house, as decided by the Dietitian following triage of the referral.
- This is not an emergency service.
- This form must be received at least 48hrs prior to a planned Dietetic visit or the resident may not be assessed.

I confirm this resident meets one or more of the below criteria for dietetic referral and I accept that inappropriate referrals will not be accepted:

- * MUST \geq 2
- * Tube feed review
- * Change in swallow requirements requiring supplement change
- * Ongoing weight loss despite oral nutrition support
- * Wound healing
- * Other: please specify

Referrer name:

Date:

Please review the form before signing.

Save this form and send it to:

dieteticreferrals@fresenius-kabi.ie