**OUTPATIENT DIETETIC REFERRAL FORM**

NHS Number…………………………………..

Surname……………….……….Title…...........

Forename………………………………………

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

Telephone/mobile………….……………….

Date of Birth…………………..……………….

Sex: M / F

Interpreter? Y / N Language?................

GP Name………………………………………

GP Practice……………………………………

Contact number……………………………….

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

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…………………………………………………..

Signature……………………………………….

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

**Please refer to the Primary Care Dietetic Referral Criteria before completion.**

**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 Nutrition & Dietetic Service, Adult Therapy Department, A804, Queens Building, Bristol Royal Infirmary, Bristol, BS2 8HW telephone 0117 342 7360**

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

February 2019

Medical Diagnosis