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**Community Dietitian Paediatric Referral Form**

**Please complete ALL fields and return to the Berkshire Health Hub**

**integratedhub@berkshire.nhs.uk** **Tel 0300 3651234 / Fax 0300 3650400**

**If complex learning needs OR if attending a special needs school, please refer to CYPIT**

**Please note incomplete referral forms will not be accepted and will be returned**

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| Name of patient:D.O.B: | NHS Number: | Referral date: |
| Has parent/carer/guardian consented to the referral? Yes [ ]  No [ ]  Best interest [ ]  | Name of person making referral: Contact telephone number:Job title/Department/Location:  |
| Ethnicity: Main language: Interpreter needed? Yes [ ]  No [ ]  |
| Patient address:Postcode:  | GP name/surgery: AddressPostcode: Telephone: |
| Name of parent/carer or guardian:Address: (If different from patient)Telephone number/s: | **Preferred appointment method:**[ ]  Face to face (clinic)[ ]  Telephone [ ]  Virtual appointment[ ]  Group workshop – Cows’ Milk Protein Allergy for under 12 months  |
| **Medical Conditions / Relevant medical history / Bloods or test results** (If allergies, please include an allergy focused history) |
| **Medication (please include any current prescription of formula milk, ONS etc):** |
| **Date**:\_\_\_\_\_\_\_\_\_\_\_    **Weight (kg) & centile:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Height & centile**:\_\_\_\_\_\_\_\_\_\_\_\_\_      ­­­­­­­­­                                                                                                                       **Previous weight or centile history if known (include dates):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **REASON FOR REFERRAL** (attach additional information if necessary) |
| ☐ Faltering Growth (weight/height <0.4th centile **or** weight crossing down 2 or > Centiles, **or** > 2+ centile difference with weight and height/length)☐ Fussy eating/restrictive eating (excluding eating disorders)☐ Coeliac disease☐ Cow’s Milk Protein Allergy / Multiple allergiesFor Non-IgE / Delayed CMPA (mild to moderate), indicate if diagnosis has been confirmed through a 2 week dairy elimination diet, followed by a re-introduction period (See BSACI or NICE Guidelines 116):☐ **Yes** or ☐ **No**  ☐ Other (please state)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ We are unable to accept requests for scientifically unsupported diet approaches**Exclusions:** * We are not commissioned for paediatric weight reducing services. There are a range of community services to refer into in See Lets get going: [www.lets-get-going.co.uk/referralform](http://www.lets-get-going.co.uk/referralform) available in Reading, Newbury and Slough.
* For clients at a special school, complex learning needs or tube fed, refer to CYPIT.
* For eating disorders, please refer to Berkshire Eating Disorder Service (BEDS) via CYPF.
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| **Other presenting symptoms/further information** (if applicable)☐ Reflux☐ Constipation ☐ Diarrhoea☐ Failure to thrive ☐ Nutritional support ☐ Nutritional deficiencies (ie iron, Vitamin D etc) |
| **Other services referred to/involved in clients care** (tick as appropriate):[ ]  OT[ ]  SLT [ ]  CAMHS[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **If referred by out of area specialist hospital/or service please attach medical history/hospital summaries** |