**CYPFND Paediatric Home Enteral Feeding REFERRAL FORM**

**Please complete and send to:** CYPFND Team ([**mailbox.CYPFND@berkshire.nhs.uk**](mailto:mailbox.CYPFND@berkshire.nhs.uk)**)** Office Tel Number: **0118 207 0932**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRAL TYPE** | | | | | | | | | | | | | | | |
| **RETAINING DIETETIC CARE**  **Please complete SECTION 1. No need to complete SECTION 2. Only complete SECTION 3 if required** | | | | | | | | **TRANSFER of DIETETIC CARE**  **Please complete SECTIONS 1 AND 2.**  **Only complete SECTION 3 if required** | | | | | | | |
| **SECTION 1 (Please complete for BOTH TRANSFER and RETAINING of dietetic care referrals)** | | | | | | | | | | | | | | | |
| **PATIENT INFORMATION** | | | | | | | | **REFERRAL DETAILS** | | | | | | | |
| **Full Name:** | | |  | | | | | **Date of Referral:** | | | Click or tap to enter a date. | | | | |
| **DOB:** |  | | **NHS Number:** | |  | | | **Name of Referrer:** | | |  | | | | |
| **Address:** | | | **GP Name/Address:** | | | | | **Job Title:** | | | **Place of work:** | | | | |
|  | | |  | | | | |  | | |  | | | | |
| **Contact Telephone Numbers:** | | | **Email Address:** | | | | |
|  | | |  | | | | |
| **Contact telephone Number:** | | | **Ethnicity:** | | | | | **Date of Discharge:** | | | **Number of Days TTOs:** | | | | |
|  | | | Please select | | | | | Click or tap to enter a date. | | | Choose an item. | | | | |
| **MEDICAL HISTORY/DIAGNOSIS** | | | | | | | | **MEDICATIONS (including dosage/frequency)** | | | | | | | |
|  | | | | | | | |  | | | | | | | |
| **Immunocompromised:** | | | Y  N | | | | |
| **ENTERAL FEEDING TUBE** | | | | | | | | **OTHER INFORMATION** | | | | | | | |
| **Reason for enteral feeding:** | | | | | | | | **Named CCN:** | | | **Named Comm Paediatrician:** | | | | |
|  | | | | | | | |  | | |  | | | | |
| **Please note we are unable to accept patients without a named Comm Paed/CCN.** | | | | | | | |
| **Make/Type:** | | | **Size:** | | | | | **GP Prescription Request sent and attached with referral form:** | | | | | | | |
|  | | |  | | | | | Y  N (required unless OTC feed or BD etc) | | | | | | | |
| **Hospital Placed:** | | | **Date Placed:** | | | | | **Abbott Hospital 2 Home Account:** | | | | | | | |
|  | | | Click or tap to enter a date. | | | | | Transferred to BHFT: | | Y N | Delivery  Made: | | Y N | | |
| **Is this patient Jejunal fed:** | | | Y  N | | | | | **Please ensure you follow the** **BHFT Paediatric Ancillary Guide when setting up Abbott H2H accounts. Link** [**https://cypf.berkshirehealthcare.nhs.uk/media/109514348/berkshire-healthcare-ancillary-guide-2022-final-220322.pdf**](https://cypf.berkshirehealthcare.nhs.uk/media/109514348/berkshire-healthcare-ancillary-guide-2022-final-220322.pdf)  **If you do not have access to Abbott H2H, please provide details of plastics/ancillaries required in SECTION 3** | | | | | | | |
| **SECTION 2 (Please complete for TRANSFER of dietetic care referrals ONLY)** | | | | | | | | | | | | | | | |
| **ANTHROPOMETRICS AND NUTRITIONAL INFORMATION** | | | | | | | | | | | | | | | |
| **Measurements (Current and Previous Hx including Date /Weight /Length or Height/ Centile):** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Other information (ie usual weight):** | | | | | | | | **Estimated Nutritional Requirements:** | | | | | | | |
|  | | | | | | | |  | | | | | | | |
| **Feed Tolerance (****e.g. hx of vomiting, diarrhoea, reflux, intolerance of other feeds):** | | | | | | | | **Allergies:** | | | | | | | |
|  | | | | | | | |  | | | | | | | |
| **SLT Advice/Swallow Assessment:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Oral intake information:** | | | | | | | | **Estimated Nutritional Oral Intake** | | | | | | | |
|  | | | | | | | | **Energy** | | **Protein** | | | | **Fluid** | |
| **ENTERAL FEEDING PLAN (Please either complete below or send a copy of the feed plan with the referral form)** | | | | | | | | | | | | | | | |
| **Current Feed Plan (Start Time/ Rate/ Water flushes/ Feed Name/ Volume/ Feed Duration):** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **SECTION 3 (Please complete WHERE REQUIRED for TRANSFER and RETAINING of dietetic care referrals)** | | | | | | | | | | | | | | | |
| **ENTERAL FEEDING SUPPLIES:** | | | | | | | | | | | | | | | |
| **If no access to Abbott Hospital2Home, please indicate plastics/ancillaries required for this patient using the \*BHFT Paediatric Ancillary Guide.** | | | | | | | | | | | | | | | |
| **Product** | | **Quantity** | | **Product** | | **Quantity** | **Product** | | **Quantity** | | | **Product** | | | **Quantity** |
| 1ml syringes | |  | | 2.5ml syringes | |  | 3ml syringes | |  | | | 5ml syringes | | |  |
| 10ml syringes | |  | | 20ml syringes | |  | 60ml syringes | |  | | | Giving Sets | | |  |
| 500ml Flexitainers | |  | | 1000ml Flexitainers | |  | 130ml sterifeed bottle | |  | | | 250ml sterifeed bottle | | |  |
| **Other Plastics/Ancillaries required (please specify description and quantities):** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **If requesting quantities in excess of BHFT Ancillary guidelines, please state reason for consideration:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **ANY OTHER RELEVANT INFORMATION:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |

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