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| For Office Use Only  Ref No: |  |
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**SELF REFERRAL FORM FOR NUTRITION AND DIETETIC SERVICE**

Title: Mr / Mrs / Ms / Miss / Dr / Other (please circle which you prefer) male/female

Client’s Last name\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s First name\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\*: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Address\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode\*:\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile / day time telephone number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your ethnic origin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your first language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require an interpreter? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of General Practitioner (GP)\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Practice\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We will usually contact your GP to inform them of ongoing treatment and check we are providing you with tailored advice. Please confirm your acceptance.

Yes 🖵 No 🖵 (please note refusal may limit self referral treatment options)

Reason for Dietitian appt\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you expect to get out of your appointment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Weight: \* \_\_\_\_\_\_\_\_\_\_\_\_Current Height: \* \_\_\_\_\_\_\_\_\_\_\_\_\_

Body Mass Index (BMI) if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you please tell us how you heard about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Any medical conditions should be made known in order to ensure appropriate care. Please fill in the medical questionnaire below. Completed Yes 🖵 No 🖵  Please tick (YES or NO) in response to ALL the conditions/statements listed:  Do you currently have or have you ever suffered with any of the following, if YES please give details  Allergy (clinical diagnosis) YES 🖵 NO 🖵 detail \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Anorexia Nervosa YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Asthma YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bulimia Nervosa YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Chronic Obstructive  Pulmonary Disease YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Crohn’s disease YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Coeliac’s Disease YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Constipation YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diabetes YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diarrhoea YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Essential) Hypertension YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Inflammatory Bowel Disease YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Irritable Bowel Syndrome YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Nausea or vomiting YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Heart problems YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Kidney disease YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mental Health Conditions YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sleep Apnoea YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Stroke YES 🖵 NO 🖵 detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Please record most recent blood results linked to your conditions (if known):  Total cholesterol: \_\_\_\_\_\_\_\_ HDL: \_\_\_\_\_\_\_ LDL: \_\_\_\_\_\_\_\_ Triglycerides: \_\_\_\_\_\_\_  Fasting blood sugar: \_\_\_\_\_\_ HbA1c\_\_\_\_\_\_  Are you on any medications? Yes 🖵 No 🖵  If yes please list or attach prescription print off: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you able to travel to clinic? Yes ♯ 🖵 No 🖵  If no, please give reason: |

I declare that this information is correct to the best of my knowledge

Your signature OR signature of parent/guardian for under 18’s\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**