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| For Office Use OnlyRef 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 detailsAllergy (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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**