

**COMMUNITY DIETETIC SERVICE REFERRAL FORM
For Care Homes**

Somerset Community Dietitians
1st Floor,
Bridgwater House,
King Square
Bridgwater,
TA6 3AR
Tel: 01278 447407

Please e-mail this referral form to DieteticsReferrals@SomersetFT.nhs.uk.
Please ensure emails are sent from a secure email account e.g. NHS.net account. If you do not have a secure email account please send completed forms by post to the Somerset Community Dietitians using the address provided on the top right of this referral form.

All mandatory fields are marked with a red star (*) and must be completed or referral may be returned.

Please note this referral form is for nutrition support referrals only, e.g. residents who are identified as at risk of malnutrition. Please ensure the **MUST Care Pathway for Care Homes in Somerset** has been followed before referring. A copy of the pathway is at the end of this referral form.

Part A: Please complete details about the resident you are referring

Date of referral*		Date referral received (Office use)	
Resident name*			
Date of birth*		NHS No.*	
Care home address*		Care home telephone No: *	
Care home e-mail (for communications)*		Note: all email correspondence will be encrypted.	
Name of GP*		GP Surgery*	
Name of person referring*		Referrer's job title*	

Part B: Pre-referral checklist

Please answer the pre-referral questions below		Yes	No
Have you watched the webinar 'Screening and supporting for malnutrition in care homes'?*		<input type="checkbox"/>	<input type="checkbox"/>
Have you addressed any underlying reasons for unintentional weight loss of the resident?*		<input type="checkbox"/>	<input type="checkbox"/>
For example, poor dentition, mouth pain, poor dexterity, mental health including bereavement, nausea, change in bowel habit and change in social circumstances.			
Have you supported the resident with a Food First approach for 4-8 weeks as per the MUST Care Pathway for Care Homes?* (The pathway is attached to the end of this form for reference)		<input type="checkbox"/>	<input type="checkbox"/>
If Yes to the above question, are you offering the following:			
1. Fortifying all the residents main meals and puddings		<input type="checkbox"/>	<input type="checkbox"/>
2. Home made milkshakes or high energy fortified puddings at least twice daily		<input type="checkbox"/>	<input type="checkbox"/>
3. High energy snacks at least twice daily		<input type="checkbox"/>	<input type="checkbox"/>
If you answered NO to any of the above questions we recommend you address these actions before referring to the Dietitian. A variety of resources for care homes can be accessed on the Somerset NHS Foundation Trust Website . If you answered YES to all of the above questions please complete the remainder of this referral form.			

Part C: Please complete details about the resident's weight history

Please give details of the resident's weight or mid-upper arm circumference (MUAC) in the past 6 months*								
1	Date:	Kg	cm	4	Date:	Kg	cm	
2	Date:	Kg	cm	5	Date:	Kg	cm	
3	Date:	Kg	cm	6	Date:	Kg	cm	
Resident's height*		M	Resident's most recent BMI* <i>Calculate using a BMI chart or the following calculation</i> $\text{Weight} \div \text{Height}^2$				Kg/M ²	
Total amount of unintentional weight loss in the past 6 months*			Kg	MUST Score*				
Has the resident recently had oedema which has now improved?*			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>	If yes , consider if any previous oedema may be a reason for the weight loss		
If you have been supporting the resident with a Food First approach for 4-8 weeks, has the resident lost further weight?*			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>	Note: Weight variation of 5% or less may be normal. Continue a food first approach if referring because of weight loss of 5% or less.		
Note: If the resident has a healthy BMI and is eating well and their GP feels there is no underlying health conditions causing weight loss, consider if gradual weight loss may be due to change in access to food or appetite related to cognitive decline if previously overweight. A dietetic referral may not be needed and weight may stabilise within a healthy weight range.								

Part D: Details about your resident's medical history and current state of health

Does the resident have any of the following conditions? (optional)	Diabetes	<input type="checkbox"/>	Dementia	<input type="checkbox"/>				
	Respiratory condition e.g. COPD	<input type="checkbox"/>	COVID-19	<input type="checkbox"/>				
	Coronary heart disease	<input type="checkbox"/>	Chronic kidney disease (CKD)	<input type="checkbox"/>				
	Cancer	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>				
	Stroke	<input type="checkbox"/>	Date of stroke					
	Progressive neurological condition e.g. Parkinson's, MND or MS	<input type="checkbox"/>	None of these conditions	<input type="checkbox"/>				
Does the resident have a pressure sore?*	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, what grade/category is it?					
If the resident has lost weight did any of the following occur at the time of weight loss?*	Hospital admission	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>	If Yes , what date/s were they admitted?			
	Chest infection or UTI	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>	Diarrhoea or vomiting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Note: If the resident was admitted to hospital or had any of the above conditions at the time of weight loss this could be the reason for weight loss and a dietetic referral may not be required. If these conditions have improved we would suggest completing the Nutrition Support Care Plan booklet and implementing for 4-8 weeks before referring to the dietitian.								
What is the resident's current state of health?*	Stable	<input type="checkbox"/>	Deteriorating	<input type="checkbox"/>				
	Palliative	<input type="checkbox"/>	I am unsure of current state of health	<input type="checkbox"/>				
If your resident is approaching the end of life we recommend reading the BDA: End of life nutrition information leaflet								
Please give details of any relevant medications prescribed (optional)								

Part E: Details about your resident's food and fluid intake

What are the resident's current eating habits? e.g. how are they eating at the moment?	Eats all of meals and snacks				<input type="checkbox"/>
	Eats more than half of meals and snacks				<input type="checkbox"/>
	Eats less than half of meals and snacks				<input type="checkbox"/>
	Eats very little e.g. teaspoons				<input type="checkbox"/>
On average how much fluid does the resident drink daily?*	More than 2000ml				<input type="checkbox"/>
	1500- 2000ml				<input type="checkbox"/>
	1000- 1500ml				<input type="checkbox"/>
	Less than 1000ml				<input type="checkbox"/>
Note: if the resident has a poor fluid intake encourage fluid rich foods. Fluid rich foods may include: full fat yoghurts, jellies, ice cream, pureed stewed fruits and custard. Please check whether patient requires thickened fluids beforehand.					
Does the resident have a texture modified diet?*	No, resident has a normal diet (IDDSI Level 7 regular or easy to chew)				<input type="checkbox"/>
	Yes, a soft & bite-sized diet (IDDSI Level 6)				<input type="checkbox"/>
	Yes, a minced & moist diet (IDDSI Level 5)				<input type="checkbox"/>
	Yes, a pureed diet (IDDSI Level 4)				<input type="checkbox"/>
	Yes, a liquidised diet (IDDSI Level 3)				<input type="checkbox"/>
Does the resident have thickened fluids?*	No, resident has normal fluids (IDDSI Level 0 thin fluids)				<input type="checkbox"/>
	Yes, slightly thick fluids (IDDSI Level 1)				<input type="checkbox"/>
	Yes, mildly thick fluids (IDDSI Level 2)				<input type="checkbox"/>
	Yes, moderately thick fluids (IDDSI Level 3)				<input type="checkbox"/>
	Yes, extremely thick fluids (IDDSI Level 4)				<input type="checkbox"/>
Does the resident have any food allergies?*	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>	If Yes , please give details:	
Is the resident on prescribed oral nutritional supplements?*	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes , please specify name, amount recommended and who prescribed them?		

PLEASE CONTINUE TO COMPLETE SECTION F ON FOLLOWING PAGE.

Part F (final section): Details about the reason you are referring your resident (and support offered)

Please give details of the reason/s why you are referring the resident?*	
Please give details of what you are already doing to improve the resident's nutritional intake?*	
For what length of time have you tried the above?	
Do you have any concerns regarding safeguarding, communication or mental capacity? <i>(If yes, please detail in additional information below)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your resident consented to this referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Additional information:	

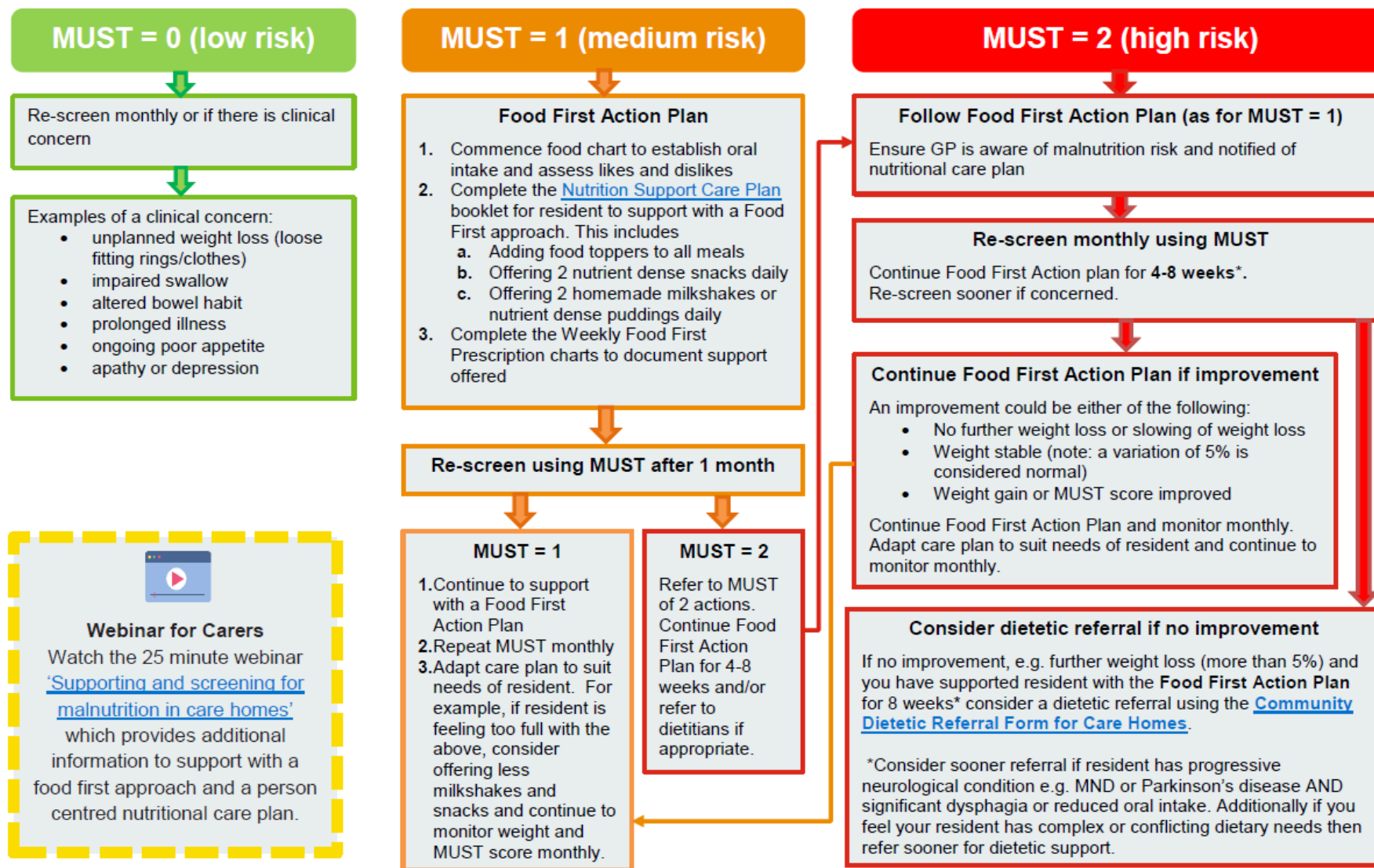
PLEASE remember to attach 4 days of food record charts to the referral

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Postal address:

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MUST Care Pathway for Care Homes in Somerset



Webinar for Carers

Watch the 25 minute webinar [‘Supporting and screening for malnutrition in care homes’](#) which provides additional information to support with a food first approach and a person centred nutritional care plan.