

Care Home Referral Form

Following nutritional screening using MUST and / or
request for dietetic consultation

Name (Mr/Ms/Mrs/Miss): Date of birth: / /

NHS no: Current place of residence:

Address: Tel no:

GP name/surgery: Tel no:

Referred by: Job title:

Tel no: Location/Address:

Signed: Date: / /

Reason for referral: Weight loss Taking nutritional supplements Texture modified diet

Tick: Urgent Routine Special diet Poor intake/appetite Other:

High risk factors (tick if applicable):

Swallowing difficulties Therapeutic diet (ie renal, diabetes)

Breathing difficulties (ie COPD) Current increased requirements (ie infection, pressure ulcers, poor wound healing)

Brief medical history (please attach):

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Current medication (please attach):

.....

MUST Screening Results			
Step 1 Current Weight: kg Current Height: Current BMI: kg/m ² MUAC left / right: cm Score:	Step 2 Weight loss in past 6 months: kg % weight loss: % Score:	Step 3 Acute Disease Affect Score: <i>(Unlikely to occur in the community)</i>	Step 4 Overall MUST Score:

Step 5: Rule out and treat potential causes of malnutrition (tick if ruled out):

Depressive mood Poor dexterity Food not tailored to likes and dislikes

Inadequate assistance Ill-fitting dentures New medication side effect

Sore/Infected mouth Social isolation Other:

Step 6: Food First Action already taken (if MUST score 1 or 2), please list:

Homemade milkshake Food fortification Fortified cup of soup/Fortified soup

Cream/High calorie shot Fortified mousse Nourishing snacks/snack box

Fruit juice/smoothie Fortified yoghurt/custard Nourishing drinks (ie Horlicks/hot chocolate)

Over the counter sip feeds (ie Complan, Nourishment, Meritene) Other (please specify):

IMPORTANT
INAPPROPRIATE AND INCOMPLETE REFERRALS WILL BE RETURNED TO THE REFERRER.
BEFORE MAKING THIS REFERRAL PLEASE CHECK THAT YOU HAVE FOLLOWED THE MUST LOCAL POLICY AND ACTION PLAN AND HAVE COMPLETED ALL SECTIONS OF THIS REFERRAL FORM.

Please also include the following:

Strict three day food and fluid record chart which includes information on food first advice implemented, portion sizes, amounts taken, any food refusal and alternatives offered.

6 months' weight history chart if available. If no weight history available, please state why eg patient recently admitted.

How to refer: Email to: ihn-tr.ipswichdieteticteam@nhs.net
 Post to: Nutrition and Dietetic Services (N040), Ipswich Hospital, Heath Road, Ipswich, IP4 5PD