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| **Referral Form for Paediatric Dietetics**  |
| **Patient Details: Please also attach any relevant, recent clinical correspondence.** |
| **Surname: Gender:** **Forename: NHS Number: Date of Birth:****Name of parent/carer: Relationship to child:****Full Address:** **Contact Number: Email:****Preferred language: Interpreter needed: YES/NO****Parent/Young person informed of referral: YES/NO**  |
| **Consent to contact by letter/phone/email/text/WhatsApp/video (Please circle)****Consent to share your child’s record with other health services who are involved in their care? YES/NO****Consent to access your child’s record held by other health services involved in their care? YES/NO** |
| **Referral information:**  |
| **ESSENTIAL INFORMATION, the referral will be rejected if not provided or up to date:****If under 1 year, weight should be taken within last 2 weeks. If over 1 year, weight taken within last 3 months.****Weight:**   **Centile: Date taken:** **Height: Centile:**   **Date taken:**  |
| **WE DO NOT ACCEPT REFERRALS FOR:** **Selective eating behaviours without a marked nutritional deficiency or weight faltering; weight management; eating disorders Or Coeliac disease \*\***

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| **P1: Faltering growth** | * Weight crossing down 2 or more centiles (under 1 year -over any time frame / over 1 year – within the past year) or weight is more than 2 centiles below the length centile
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| **P2: Nutritional deficiencies** | * Please specify specific deficiency and attach recent blood results.
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| **P3: Cow’s milk protein allergy (CMPA)****Please note we do not hold the budget for infant formulae, decision making on prescriptions lies with the individual GP. \*** | * Is this immediate (IgE mediated) CMPA or delayed (non-IgE mediated) CMPA ? (please tick)
* Are they on a prescribed infant milk? **YES/NO** If so which one?
* Has the diagnosis been confirmed by challenge with either a cow’s milk formula, by reintroducing milk into the maternal diet, or via allergy testing? **YES/NO**
* Have their symptoms settled on the milk free diet? **YES/NO**
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| **P4: Other food allergy** | * Confirmed or suspected food allergy. Please specify:
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| **P5: Gastrointestinale.g. IBS, Constipation, diarrhoea**  | * Please specify:
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| **P6: Home enteral feeding** | * Please give further details and attach current feeding plan.
* Are they set up on Nutricia Homeward? **YES/NO**
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 **Relevant medical history/medications:** |
| **What is the desired outcome of Dietetic input?**  |
| **Further Information: e.g. Safeguarding, other health professional involvement, Gillick Competence etc.** |
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| **GP Details:** |
| **Named GP: GP Telephone:** **GP Practice Name and Full Address:**  |
| **Referrer details:** |
| **Full Name: Profession: Date:** **Full Address:** **Tel: Email:**  |
| **Please send referral form to: (telephone referrals not accepted)** |
| **Post: Children’s Dietetic Service, The Peacock Centre, Brookfields Campus, 351 Mill Road, Cambridge CB1 3DF. For queries please telephone: 0300 029 5050.** |
| **Email: CCS-TR.paediatric-dietitians@nhs.net** |

\*ICS Cow's Milk Allergy Pathway
<https://www.cpics.org.uk/download.cfm?doc=docm93jijm4n2413.pdf&ver=4736&UNLID=9478784652024417125046>

\*\*Signposting
**Weight management**: please contact Maximus: <https://cap.maximusuk.co.uk/> ,
**Eating disorders**: please contact CPFT NHS Trust for input <https://www.cpft.nhs.uk/younited/> ,
**Selective Eating**, with no nutritional deficiency or weight loss: Please watch our patient webinars videos available under the "fussy or selective eating" tab
<https://www.cambspborochildrenshealth.nhs.uk/services/cambridgeshire-and-peterborough-childrens-nutrition-and-dietetics/>
**Coeliac Disease**: please contact your local hospital