## York Teaching Hospit#73D302

**Outpatient Referral Form for Dietetic Advice**

**Contact Details:** Nutrition & Dietetic Dept, York Hospital, Wigginton Road, York, YO31 8HE

**Phone:** 01904 725269 **Email**: [yhs-tr.yorkdietitians@nhs.net](mailto:yhs-tr.yorkdietitians@nhs.net)

**Patient Name: NHS Number:**

**Date of Birth: Patient contact number:**

**GP: Consultant:**

**Diagnosis and any relevant treatment/surgery plan:**

**Reason for referral:** Nutrition Support 🞏 Weight Management 🞏

Other 🞏 (please state):

**Any other relevant information:**

**Nutritional screening (Nutrition Support referrals only):**

Please use online Malnutrition Risk Screening Tool (MUST) calculator:

<https://www.malnutritionselfscreening.org/self-screening.html>

**MUST SCORE:\_\_\_\_\_\_\_**

Weight :\_\_\_\_\_(kg) Height: \_\_\_\_\_ (m) BMI**:** \_\_\_\_\_ (kg/m2)

% weight loss over 3-6 months: \_\_\_\_\_

**Symptoms affecting oral intake (Nutrition Support referrals only):**

Nausea 🞏 Poor Appetite 🞏 Dysphagia 🞏 Sore mouth 🞏 Fatigue 🞏

Taste changes 🞏 Fatigue 🞏 Other 🞏 (please state):

Has the patient been given first line advice to help improve oral intake?

Yes 🞏 No 🞏

If yes, please state advice provided (including any written information):

Has the patient provided consent for this referral?

Yes 🞏 No 🞏 Unable to consent 🞏

Could this patient attend an outpatient appointment with the dietitian?

Yes 🞏 No 🞏

Could this patient participate in a telephone or virtual consultation with the dietitian?

Yes 🞏 No 🞏

Referrer name (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_