

**ADULT DIETETIC REFERRAL CRITERIA FOR ENFIELD COMMUNITY SERVICES**

Please send/fax to: Nutrition & Dietetic service, Community Therapies Office, Magnolia Building, St

Michael’s Centre, Gater Drive, Enfield EN2 0JB Tel: 020 8375 2973 or 020 8702 5660 Fax: 020 8364 5011.

**BEFORE REFERRING**: Is the patient ready to make dietary changes? Has first line dietary advice been given? Has the patient consented to referral?

**Please include any other information required as indicated below. If the information is incomplete, the referral will not be accepted and this will result in a delay to accessing treatment**.

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| **REASON** |  | **CRITERIA REQUIRED** | **INFORMATION REQUIRED**  **If not supplied, the referral will be returned.** |
| **DIABETES** | Group Session  Group Session or 1 to 1 | * All newly diagnosed Type II * Type II. Poor blood glucose control >58mmol/mol not under diabetes service.     **Patients on insulin should be referred via the specialist diabetes service (at Forest Row) to see a dietitian.** | Date of diagnosis  HbA1c  Relevant Medication |
| **OBESITY** | Group Session  1 to 1  Education only | 1 or more co morbidity (e.g. hypertension, high cholesterol) and BMI ≥ 35 | All - Height and Weight or Waist Circumference.  Details of co-morbidities e.g. blood pressure reading, lipid results. |
| **CARDIOVASCULAR** | 1 to 1  1 Session only | * 10 year CVD risk above 20% (see Cardiovascular Risk Prediction Charts (BNF 53: March 2007). | Lipid results  Relevant Medications |
| **NUTRITIONAL SUPPORT** | 1 to 1 | * **MUST** Malnutrition screening tool of ≥ 3 * **MUST** Malnutrition screening tool of ≥ 2 and on supplements for at least 3 months   **Referral to be made if deemed beneficial to patient’s quality of life.** | MUST score, Weight, Estimated height (if unable to measure)  All patients should be given food first advice and then started on over the counter or first line powdered nutritional supplements (if suitable) before referral to the Dietetic Department. |
| **NUTRITIONAL**  **SUPPORT**  **NURSING/CARE HOMES** | 1 to 1 | * **MUST** Malnutrition screening tool of ≥ 3 * **MUST** Malnutrition screening tool of ≥ 2 and on supplements for at >3 months   **Referral to be made if deemed beneficial to patient’s quality of life.** | MUST score, Weight, Estimated height (if unable to measure)  **Food chart for 5 days**  All patients should be given food first advice and then started on over the counter or first line powdered nutritional supplements (if suitable) before referral to the Dietetic Department. |
| **DYSPHAGIA** | 1 to 1 | * Reduced swallow function and change in safe consistency of food or fluid recommended | Speech and Language Therapy assessment. Date of assessment and recommendations made. |
| **NASOGASTRIC TUBE OR GASTROSTOMY IN PLACE** | 1 to 1 | * Home Enteral Feeding | Feeding Regime  Discharge report |
| **GASTROINTESTINAL AUTOIMMUNE PROBLEMS** | 1 to 1 | * Inflammatory Bowel Disease, including Crohn's Disease, Ulcerative Colitis. * Irritable Bowel Syndrome diagnosed using NICE guidance * Coeliac Disease - newly diagnosed and annual   review. | Date of diagnosis  Attach test results  Biopsy report/ tTGA must be provided for patients with IBS if the patient still consumes wheat. |
| **FOOD INTOLERANCES AND ALLERGIES** | 1 to 1 | * Allergy/Intolerance | Diagnostic report |
| **NUTRITIONAL DEFICIENCIES** | 1 to 1 | * Anaemia | Attach results to indicate deficiency. |
| **EXCLUSIONS** |  | * Patients with continued treatment from Acute Dietetic Services. * Classified Eating Disorder. * Diabetic patients requiring insulin (refer via diabetes service). |  |

Updated August 2016