|  |
| --- |
| **ADULT MALNUTRITION DIETETIC SERVICE REFERRAL FORM** **To be used for Care Home Residents** |

## Send referrals to: FAX 0300 008 3168 or EMAIL CLCHT.BNUTRITIONSUPPORT@nhs.net

## To confirm receipt of referral call: 020 8937 7121

## To speak to a Dietitian call: 020 8937 7121\*Incomplete referrals may not be accepted\*

#### SECTION 1: PATIENT INFORMATION and HISTORY

|  |  |  |
| --- | --- | --- |
| Patient Name: | Surname: | Sex: Male [ ]  Female [ ]   |
| DOB: | NHS No: | Tel:Email: |
| Address: |
|  | Postcode: |
| Ethnicity: | Smoking status: |
| Interpreter Required: Yes [ ]  No [ ]  | Language: |
| GP name & Practice:  |
| Does this patient have access needs? (e.g. requires letters in large print, easy read or with symbols/pictures, sign language interpreter etc) YES NO (If yes please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Patient is aware and consents to this referral YES NO  |
| Safeguarding concerns? YES NO (If yes please provide further details in social history section) |
| Contact details for other services involved *(if applicable*): |
| Medical History:Medications: |
| Social History: |

**SECTION 2: CLINICAL INFORMATION:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date measurements****taken** | **Weight (kg)** | **Height** **(m)** | **Mid-upper Arm Circumference (MUAC) – *this must be recorded if unable to measure weight***  | **Body Mass Index (BMI)** | **Weight loss in kg** **over past 3-6 months** | **Malnutrition Universal Screening Tool score (MUST)**  |
|  |  |  |  |  |  |  |

##### SECTION 3: REASON FOR REFERRAL

|  |  |
| --- | --- |
| **Referral Reason** | **Clinical information required** |
| [ ]  Prescribed Oral Supplement Drinks | Name of supplement(s) prescribed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Daily dosage of supplement (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Malnutrition: MUST (Malnutrition Screening Tool) Score 2 or more**See referral pathway** | **Please note for a referral to be accepted first line dietary advice must have been trialled for a one month period, otherwise the referral will not be accepted**Please outline first line dietary advice already trialled: |

## SECTION 4: OTHER RELEVANT INFORMATION

## (e.g. Hospital discharge, mental health, learning disabilities, SALT, reports)

|  |
| --- |
|  |

##### SECTION 5: REFERRER – referrals will not be accepted without a printed name and signature

|  |  |
| --- | --- |
| **Name (Printed):** | **Signature:** |
| **Profession:** | **Date:** |
| **Address: Postcode:****Tel: Fax:** |

**Care Homes Referral Pathway to Adult Malnutrition Dietetic Service**

**Identify risk of malnutrition using ‘MUST’ to obtain patient score. Document in patients records**

**‘MUST’ Score = 1**

**Medium Risk**

**‘MUST’ Score = 0**

**Low Risk**

**‘MUST’ Score = 2 or higher**

**High Risk**

**Assess underlying causes of malnutrition**

**Refer to section A overleaf**

**Rescreen monthly or upon clinical concern**

**Write care plan include first line dietary advice – refer to section B overleaf**

* **Fortify 1 food at each meal**
* **Offer 2 snacks each day** between meals
* Offer at least **1 nourishing drink/day**

**Set and document a treatment goal to improve patient’s nutrition and develop and document a care plan**

* **Weigh weekly**
* **Keep daily food record chart**

**Review in 4 weeks or before if clinical need demands**

**Write care plan include first line dietary advice – refer to section B overleaf**

* **Fortify 1 food at each meal**
* **Offer 3 snacks each day** between meals
* Offer at least **2 nourishing drinks/day**

**Set and document a treatment goal to improve patient’s nutrition and develop and document a care plan**

* **Weigh weekly**
* **Keep daily food record chart**

**Review in 2 weeks or before if clinical need demand**

**At Review: Repeat ‘MUST’ Score**

* **Assess diet changes**
* **Review care plan**
* **Document in patient record**

**MUST Score =2 or higher**

**No Improvement**

**Still losing weight/ no improvement in intake:**

* Reinforce care plan and make any necessary amendments
* Reassess underlying problems and treat
* Weigh weekly
* Keep daily food record chart

**Refer to the Dietitian using the service referral from. Copies available by calling 0208 937 7121**

**Email referrals to: CLCHT.BNUTRITIONSUPPORT@NHS.NET**

**Fax referrals to:**

**0300 008 3168**

**MUST Score =1 or MUST score=0**

**Improvement/patient stable**

Weight stable or increasing, appetite improved:

* Reinforce care plan
* Reassess after one month

**Continue to review until treatment goals met:**

* Continue to monitor for

3 months

* If problems reoccur – return to start of flow chart

**All patients prescribed oral nutritional supplements e.g. Ensure Plus can be referred directly to the dietetic department using the service referral form.**

**All patients need to have their MUST screen completed to enable the referral to be accepted**

 **Section A: A Guide to Assessing Underlying Causes of Malnutrition and Treatment Options**

Poor emotional or mental health, e.g. depression, isolation, bereavement

Discuss management with GP, offer resident the option of eating meal with other residents in dining room, offer assistance at mealtimes

Poor dentition

Consider referral to Dentist

Advise patient on soft/appropriate diet

Difficulties or unable to swallow

Refer to Speech and Language Therapy

Medical condition/symptoms causing poor appetite/intake i.e. COPD, Cancer, diarrhoea, constipation nausea

Discuss management with GP

Requires assistance with eating and drinking

Provide feeding assistance at all mealtime and snack times and offer fluids regularly. Consider adapting eating environment,

and utensils used.

**Section B: First Line Dietary Advice**

**Food First Advice**

All patients at risk of malnutrition (‘**MUST’ score of 1 or more**) should be given Food First advice. Simple dietary changes have the potential to significantly increase a patient’s calorie intake. Consider including the below suggestions in your care plan.

|  |  |  |
| --- | --- | --- |
|  **Snacks**  | **Nourishing Drinks** | **Foods to Fortify with** |
| 1 slice of cake2 x biscuits & cheese 1 croissant 1 squares of chocolate 1 packet of crisps 1 handful of nuts1 pot of full fat yoghurt 1 English muffin2 digestive biscuits | ***Rather than tea/coffee/water offer:***Hot chocolate prepared with full fat milk Malted drinks prepared with full fat milkHomemade milkshakesFruit smoothies /juice\*200ml of full fat milk1 dessert spoon of milk powder added to drink/ 200ml*\* Fruit juice is lower in energy*  *than other drinks****Prepare enriched mill and use this to prepare all hot drinks**** Add 4 heaped tablespoons (60g) of skimmed milk powder to a pint of full cream/full fat milk
* Try to consume a pint of enriched milk per day
 | Butter/ margarine ½ tablespoonCheese 1 tablespoon Custard (or soya alternative)1 ladleDouble cream 2 tablespoonsEvaporated/condensed milk 2 tablespoonsGround nuts e.g. almond 1 tablespoonHummus 1 tablespoonIce cream 1 scoopJam 1 tablespoonMayonnaise 1 tablespoonMilk powder 1 tablespoon Peanut butter 1 tablespoonPesto 1 tablespoonSugar/ honey 1 tablespoon |