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| **Referral Form for Children’s Dietetics** |
| **Patient Details: Please also attach any relevant, recent clinical correspondence.** |
| **Surname: Title: Gender:**  **Forename: NHS Number: Date of Birth**  **Name of parent/carer: Relationship to child:**  **Full Address:**  **Home tel: Mobile tel: Email:**  **Preferred language: Interpreter needed: YES/NO**  **Parent informed of referral: YES/NO Consent to contact by letter/phone/email (Please circle)** |
| **Referral information:** |
| **Weight:**   **Centile: Date taken:**  **Height: Centile:**   **Date taken:**  **BMI: Centile: Date taken:** |
| |  |  | | --- | --- | | **Faltering growth** | * Weight crossing down 2 or more centiles or more than 2 centiles between weight and length centile. | | **Nutritional deficiencies/ selective eating** | * Please specify: | | **Food allergy/intolerance** | * Confirmed or suspected food allergy or intolerance. Please specify: | | **Gastrointestinal** | * Please specify: | | **Home enteral feeding** | * Please give further details: |   **Note: We are unable to accept referrals for weight management or eating disorders.\***  **Relevant medical history/medications:** |
| **Further Information: e.g. safeguarding, other health professional involvement, 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: 01223 218064.** |
| **Email: CCS-TR.paediatric-dietitians@nhs.net** |

\*please contact Everyone Health (Cambs) and Solutions for Health (Peterborough) for weight management and CPFT NHS Trust for eating disorders input.