**Referral to the Community Dietitian for nutritional support:**

**Referrals not meeting the criteria or not fully completed will be declined**

|  |  |  |
| --- | --- | --- |
| **Resident’s Full Name:**    **Date of Birth: NHS No:** | | |
| **Care Home:**  **Telephone No:** | | |
| **Summary Medical History/Diagnosis:** |  | |
| **Other health professionals involved with resident?**    **GP informed YES/NO** |  | **Previous Dietetic**  **Referral**  **YES/NO** |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Weight** | **Weight Last**  **Month** | **Weight 2**  **Months ago** | **Weight 3**  **Months ago** | **Height** (actual /estimated) | **Current**  **BMI** | **MUST Score\*** | **Nutrition risk group**  *(please circle)* | | |
|  |  |  |  |  |  |  | **Low** | **Med** | **High** |
| **Date:** | **Date:** | **Date:** | **Date:** |

**\*Please calculate MUST score based on last 3 months’ weight rather than 6 months’**

|  |  |  |  |
| --- | --- | --- | --- |
| **1** | Is the resident at **high risk** of undernutrition? (assessed via screening tool) *(circle)* | **Yes** | **No** |
| **2** | Has the resident been at **high risk** & showed no improvement despite ‘food first’ approach for 4 weeks i.e. food fortification, nourishing drinks, nourishing snacks *(circle)*  **Please detail ‘Food First Actions’ trialled on the Nutrition Assessment- First Line Care Plan- this must be included as part of the referral** | **Yes** | **No** |
| **3** | Has the resident lost weight in the past three consecutive months? *(circle)* | **Yes** | **No** |

If any questions answer **No**: please **do not refer** to the dietitian, but refer to the ‘Food First’ guidelines for advice. If the answer to ALL questions is **YES:** refer the resident to the dietitian.

## High Priority Dietetic referral

A resident may be high priority if:

* Category 3/4/Unstageable Pressure Ulcer **AND** MUST of 2 or above
* New enteral feed discharged from HDFT or out of area
* Individual being considered for enteral tube insertion
* Malabsorption –such as a high output stoma (>1.5l/day)
* MUST of 4 (calculated over 3 months)
* Dysphagia limited to liquid diet only

If a resident is high priority please state reason…………………….…………………………………………………………..

**COMPLETE ALL SECTIONS OF REFERRAL FORM including:**

**3 DAY FOOD & FLUID CHART & NUTRITION ASSESSMENT - FIRST LINE CARE PLAN**

**Return to: Email: hdft.carehomediet@nhs.net**

**If you have any queries please contact the Nutrition & Dietetic department. Tel: 01423 553329 or Email: hdft.carehomediet@nhs.net**

**NUTRITION ASSESSMENT- FIRST LINE CARE PLAN**

The assessment process enables a specific treatment plan to be developed for the individual. It aims to identify any underlying causes of malnutrition and any possible interventions that need to be actioned.

|  |  |
| --- | --- |
| **Problem** | **Action** |
| **Swallowing problems** | Consider referral to Speech & Language Therapists if indicated (discuss with GP)  Ensure appropriate texture food & fluid is offered  Fortify modified consistency diet & offer naturally thick fluids if required |
| **Chewing problems/**  **Sore mouth /**  **Poor Dentition/** | Assess Oral Hygiene, treat as needed  Get sore mouth / mouth ulcers treated  Check teeth/dentures-refer to Dentist if needed |
| **Consider if a medical condition is:-**  **a) Increasing requirements** *(e.g. pressure sore, infection)*  **b) Affecting dietary intake** *(e.g. vomiting, diarrhoea, constipation, depression, pain)* | Seek medical advice.  Ensure treatment to control / treat any identified condition is provided  Consider side-effects of medications. Request a medication review |
| **Unable to feed independently** | Position correctly-consider referral to Occupational Therapist or Physiotherapist  Provide appropriate cutlery/crockery  Provide assistance/supervision at meal and snack times |
| **Consistently not finishing meals despite assistance** | Assess comfort at mealtimes – e.g. need to empty bowels, pain, positioning  Consider environment & minimise distractions  Find out likes/dislikes & mealtime preferences from patient or relatives  Use verbal or visual prompts to help eating  Explore anxieties or communication difficulties  If signs of depression or pain seek medical advice  Encourage 3 **small fortified** meals/snacks a day and *at least* 2 **nutritious** snacks and 2 **nourishing** drinks a day |
| **Consistently refusing food or fluid** | As above  If at risk of dehydration: Encourage drinks after and in between each meal aiming for 6-8 cups/day & seek medical advice |
| **No interest in food**  **Depression (untreated)** | If depressed seek medical advice  Provide encouragement & support with preferred meals/snacks |
| **Constant activity/agitation** | Provide nutritious snacks - finger foods throughout day  Assess mealtimes - comfort, food and fluid intake and establish cause of agitation |

Please document below any problems identified & actions taken- also include any ‘FOOD FIRST ACTIONS’ taken i.e. types of nourishing snacks, drinks & fortification taken & whether successful

|  |  |  |
| --- | --- | --- |
| **PROBLEM IDENTIFIED:** | **ACTION TAKEN:** | **DATE:** |
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**Food and Fluid Chart (3 days)**

To be used as clinically indicated (e.g. reduced appetite, weight loss) and to be sent as part of the referral process to the Dietitian

Name:............................................................................................... ................. Date: ....................................

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DAY 1**  **Date:** | **Description of Food / Drink**  *(please specify)*  **(slice, scoop, tbsp, ladle, cup)** | **Amount eaten**  ***(please tick)*** | | | | | **Comments /**  **Alternatives offered/Sign** |
| 0 | **¼** | **½** | **¾** | all |
| **BREAKFAST** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **MID MORNING** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **LUNCH** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **MID AFTERNOON** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **EVENING MEAL** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **SUPPER** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **DAY 2**  **Date:** | **Description of Food / Drink**  *(please specify)*  **(slice, scoop, tbsp, ladle, cup)** | **Amount eaten**  ***(please tick)*** | | | | | **Comments /**  **Alternatives offered/Sign** |
| 0 | **¼** | **½** | **¾** | all |
| **BREAKFAST** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **MID MORNING** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **LUNCH** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **MID AFTERNOON** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **EVENING MEAL** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **SUPPER** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **DAY 3**  **Date:** | **Description of Food / Drink**  *(please specify)*  **(slice, scoop, tbsp, ladle, cup)** | **Amount eaten**  ***(please tick)*** | | | | | **Comments /**  **Alternatives offered/Sign** |
| 0 | **¼** | **½** | **¾** | all |
| **BREAKFAST** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **MID MORNING** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **LUNCH** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **MID AFTERNOON** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **EVENING MEAL** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |
| **SUPPER** |  |  |  |  |  |  |  |
| Food |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Fluids |  |  |  |  |  |  |  |