**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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|  |  |  |
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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 |  |  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  |  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  |  |  |  |  |  |  |