**Paediatric Dietetic Service for Home Enteral Feeding**

**This referral form is for Home Enteral Feeding only. For all other dietetic referrals please use the ‘Paediatric Dietetic Outpatient Referral Guide’ via RMS**

**We cannot accept incomplete referrals *Our waiting times can be long. Please maintain contact with the patient and continue to monitor until you receive correspondance that Dietetic contact has been made.***

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| --- | --- | --- | --- |
| Surname |  | NHS No |  |
| Forename |  | D.O.B |  |
| Address | | Consent |  |
|  | | Gender |  |
| Telephone |  |
| Email |  |
| Post code |  | Name or parent/ carer |  |

|  |  |
| --- | --- |
| Relevant social history |  |
| Safeguarding considerations |  |
| Other services involved |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Do you consider this referral urgent? | Yes/ No | | Why? |  | | | | |
| Is this referral for an infant under 12 months who was born preterm (<37 weeks gestation) | | | | | YES/NO | | | |
| Diagnosis | |  | | | | | | |
| Weight (date) | |  | | | | Centile |  | |
| Height (date) | |  | | | | Centile |  | |
| Body mass index (for children >2 years) | |  | | | | Centile |  | |
| Details of previous growth | |  | | | | Current prescriptions | |  |
| Relevant past medical history | |  | | | |
| *Continued on next page* | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Reason for feeding | |  | | |
| Tube in situ |  | | Date tube placed |  |
| Current feeding regime | | | | |
|  | | | | |
| Feed history (including any tolerance issues | | | | |
|  | | | | |
| For discharging hospitals: TTO information (please ensure at least 2 weeks TTO are provided to enable enough time for local training and supply) | | |  | |

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| --- |
| Please detail any additional information relevant to this referral |
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