Dietitian Referral Form For Nursing Home Residents

FRESENIUS KABI
caring for life

Resident Name	
Resident DOB	
Nursing Home name	
Name of referrer and job title	
Date of referral	
Telephone number	
Email address	

Consent
Please select as appropriate:

The resident has consented to this referral

The referral has been made in the resident's best interests

Medical History	
Reason for Dietetic referral	
Current clinical status: acute disease/recent infection etc or clinically stable (please specify)	

Is the resident receiving end of life care?	Yes	No
Has ceiling of care been discussed?	Yes	No
Is this resident a potential candidate for enteral tube feeding?	Yes	No

Skin integrity	Intact	Pressure ulcer*	Other*
*Please specify area and grade:			

Current diet and fluid regime Method of intake:	Oral feeding/drinking	PEG/RIG	PEG/RIG + Oral

Has food intake recently been reduced?	Yes*	No
*If Yes, please supply further details:		
Please attach completed food and fluid chart (available @ www.clinicalnutrition.ie) and a current medications list.		

Any nausea/vomiting?	
Mobility level	
Recent abnormal biochemistry	
Blood sugars (if applicable)	
Bowel motility	

Current swallow recommendations

Never previously assessed

If previously assessed: SLT name: Date:

FOOD	LIQUID
Level 7: Regular	**Level 0:** Thin
Level 7a: Regular Easy to Chew	**Level 1:** Slightly Thick
Level 6: Soft and Bite-Sized	**Level 2:** Mildly Thick
Level 5: Minced and Moist	**Level 3** Moderately Thick
Level 4: Pureed	**Level 4:** Extremely Thick
Level 3: Liquidised	

Weight History

Weight History	Weight (kg)	BMI (kg/m²)	MUST score
Current			
Last month			
3 months ago			
6 months ago			

Fresenius Kabi Ltd
Unit 3B Fingal Bay, Balbriggan, Co. Dublin, Ireland
www.fresenius-kabi.ie
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Dietary requirements:

None   Lactose intolerant   Diabetic   Nut allergy   Fortified diet   Coeliac

Please provide prescribed oral nutrition support (if applicable) and document how much of each they are managing:	
If tube feed patient please document feed name, volume, rate and hours of feed:	

By sending this referral I understand:

- The resident (or referrer if the resident is unable to give informed consent) understands & acknowledges that their personal information will be securely used, stored and shared in order to provide ongoing clinical care.
- The information obtained by this form will be used for the purposes of therapeutic assessment only and will not be used by any other party. For more information on how we use this data please click here.
- Incomplete referrals will be returned and may delay assessment time.
- Assessments may be carried out remotely or in house, as decided by the Dietitian following triage of the referral.
- This is not an emergency service.
- This form must be received at least 48hrs prior to a planned Dietetic visit or the resident may not be assessed.

I confirm this resident meets one or more of the below criteria for dietetic referral and I accept that inappropriate referrals will not be accepted:

* MUST ≥ 2
* Tube feed review
* Change in swallow requirements requiring supplement change
* Ongoing weight loss despite oral nutrition support
* Wound healing
* Other: please specify

Referrer name: Date:

Please review the form before signing.

Save this form and send it to:
dieteticreferrals@fresenius-kabi.ie

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