

**All fields are mandatory, however, if any of the requested information is not available please either indicate**

**reason or contact the service to discuss before referring.**

**Referrals from Care & Residential Homes should be completed by the Care / Residential Home only. Referrals**

**will not be accepted if not accompanied by up to date MUST Step 5 paperwork. The following link will direct you**

**to information and guidance on completing MUST Step 5:** [**MUST Calculator**](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.bapen.org.uk%2Fscreening-and-must%2Fmust-calculator&data=05%7C01%7CAngela.Monaghan%40ggc.scot.nhs.uk%7Cdaf9fe1efbc6454f26e908db821d7bb0%7C10efe0bda0304bca809cb5e6745e499a%7C0%7C0%7C638246835354929142%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=KxVlsyOsP05kTzPUHlbhcHCjhrCMb2pafy71Q1dk5bg%3D&reserved=0)

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| --- | --- | --- | --- | --- | --- |
| **Date:** | | **Patient Name:** | | **CHI:** | |
| **Patient Address:**  **Tel No:** | | | **GP Name & Address:**  **Tel No:** | | |
| **Appointment Type**  **OUT PATIENT APPOINTMENT**  **HOME VISIT**  **Home visits are for HOUSEBOUND patients only, is any lone working risk associated with this patient**  **NO  YES please give details below** | | | **Referrer Name & Address:**  **Tel No:**  **Designation / Job Title :**  **Referrer’s signature:…………………………………** | | |
| **HEIGHT:** | **WEIGHT:** | | **BMI:** | | **MUST Score:**  **Referrals from Residential & Care Homes are required to be accompanied by MUST Step 5 paperwork** |
| **REASON FOR REFERRAL:** *please refer to the Community Dietetic referral criteria linked here for convenience:* | | | | | |
| **Please provide details of any first line intervention or advice already given:**  *Please include information such as date discussed, dietary advice leaflets issued and agreed goals. If no 1st line advice given, please state reason:* | | | | | |
| **Please provide information on medical history, current medication / medical treatment and details of any current Oral Nutrition Supplements (ONS):** | | | | | |
| **Please provide details of any recent / relevant blood results:**  *Please include dates where possible* | | | | | |
| **Please provide any other relevant information for e.g. social factors or mental health issues:** | | | | | |