parkside hospital

NUTRITION & DIETETIC SERVICE SELF REFERRAL

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other _____ Male ☐ Female ☐

Client's Last name*: _____ Client's First name*: _____

Date of Birth*: _____ /_____ /_____

Address*: _____

_____

Telephone number*: _____ Mobile/day time telephone number*: _____

E-mailaddress*: _____

Preferred method of contact: Telephone ☐ Mobile ☐ E-mail ☐ Letter ☐

What is your ethnic origin? _____

What is your first language? _____

Do you require an interpreter? _____

Name of treating Consultant*: _____

Address of Practice*: _____

_____

General Practitioner (GP)*: _____

Address of Practice*: _____

_____

We will usually contact your Consultant/GP to inform them of ongoing treatment and check we are providing you with tailored advice. Please confirm your acceptance.

YES ☐ NO ☐ (please note refusal may limit self referral treatment options)

Reason for Dietitian appointment* _____

What do you expect to get out of your appointment?

_____

Current Weight: _____ Current Height: _____ Body Mass Index (BMI) if known: _____

Can you please tell us how you heard about us? _____

*Mandatory and must be completed. Incomplete forms will be returned.

Any medical conditions should be made known in order to ensure appropriate care.
Please fill in the medical questionnaire below. Completed: Yes ☐ No ☐

Please tick (YES or NO) in response to ALL the conditions/statements listed:
Do you currently have or have you ever suffered with any of the following, if YES please give details

Allergy (clinical diagnosis)	YES ☐	NO ☐	detail _____
Anorexia Nervosa	YES ☐	NO ☐	detail _____
Asthma	YES ☐	NO ☐	detail _____
Bulimia Nervosa	YES ☐	NO ☐	detail _____
Chronic Obstructive Pulmonary Disease	YES ☐	NO ☐	detail _____
Crohn's disease	YES ☐	NO ☐	detail _____
Coeliac's Disease	YES ☐	NO ☐	detail _____
Constipation	YES ☐	NO ☐	detail _____
Diabetes	YES ☐	NO ☐	detail _____
Diarrhoea	YES ☐	NO ☐	detail _____
(Essential) Hypertension	YES ☐	NO ☐	detail _____
Inflammatory Bowel Disease	YES ☐	NO ☐	detail _____
Irritable Bowel Syndrome	YES ☐	NO ☐	detail _____
Nausea or vomiting	YES ☐	NO ☐	detail _____
Heart problems	YES ☐	NO ☐	detail _____
Kidney disease	YES ☐	NO ☐	detail _____
Mental Health Conditions	YES ☐	NO ☐	detail _____
Sleep Apnoea	YES ☐	NO ☐	detail _____
Stroke	YES ☐	NO ☐	detail _____

Please record most recent blood results linked to your conditions (if known):

Total cholesterol: _____ HDL: _____ LDL: _____ Triglycerides: _____

Fasting blood sugar: _____ HbA_{1c} _____

Are you on any medications? YES ☐ NO ☐

If yes, please list or attach a copy of your prescription: _____

_____

I declare that this information is correct to the best of my knowledge

Your signature (or signature of parent/guardian for under 18's)*: _____

Name: _____ Date: _____

*Mandatory and must be completed. Incomplete forms will be returned.