**CSH Single Point of Access (SPA) Community Services Referral Form**

*\*Mandatory field must be completed for referral acceptance*

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| **Community Paediatric Dietetics** |
| *Surrey Downs Health & Care Partnership catchment area.*  *Remote & Outpatient service. Domiciliary service for home enteral tube feeds only.*  [**https://www.surreydowns-hcp.org/primary-care-networks**](https://www.surreydowns-hcp.org/primary-care-networks) |

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| **\*Personal Details** |  |
| Surname: | Mr Mrs Miss |
| Forename: | Date of Birth: |
| Address | NHS No: |
| Home Telephone Number:  Email address: Consent to use: Yes / No | Mobile: |
| Does the patient have any communications needs for spoken communication? | YES/NO (if Yes please detail) |
| Does the patient require an Interpreter? | YES/NO (if Yes please detail) |
| Does the patient have any communication needs for written communication? | YES/NO (if Yes please detail) |
| GP Name, Address & Telephone Number: | |
| Next of Kin /Carer’s details | Name:  Contact details: |
| Is the Child known to Social Services? | YES/NO |

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| **\*Referrer Details:** | |
| Referrer’s Name & Organisation: |  |
| Referrer’s telephone number: |  |
| Referrer’s email address: |  |
| Date of referral: |  |

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| **\*Consent:** |
| Has consent been obtained for this referral? YES / NO  Please detail third party consent if applicable: |

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| **Alerts:** |
| Are there any alerts relating to this patient: |

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| **\*Reason for Referral:** |
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| **Urgent:** YES / NO (If YES, please detail why) |

**\*Please include an up-to-date EMIS or Discharge Summary that includes any past medical history, medication and diagnostic information.**

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| **Community Paediatric Dietetics (Surrey Downs Health & Care Partnership Area)**  Current weight (kg): Date recorded:  Current length/height (cm): Date recorded:  **Tick the boxes below that apply to the child**   |  |  |  |  | | --- | --- | --- | --- | | Tube feeding |  | Autism/ASD and ADHD **with** selective eating |  | | Mild/moderate food allergy/intolerance (severe or multiple food allergy should be referred to Epsom Hospital Allergy Service) |  | Fussy/Selective eating **with** missing 2 or more food groups |  | | Overweight children under 5 years of age, i.e. weight ≥2 centile above height |  | Physical feeding difficulties +/- faltering growth |  | | Nutritional deficiencies e.g. anaemia |  | Preterm babies with feeding problems +/- faltering growth |  | | Faltering growth/failure to thrive – weight ≥2 centile below height; with/without stunting (length down ≥2 centiles) |  | Persistent vomiting/Reflux/Gastro oesophageal reflux |  | | Vegan and vegetarian advice |  | Coeliac disease |  | | Other |  |  |  | |

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| **Ethnic Background** | | | | | | | |
|  | Tick |  | Tick |  | Tick |  | Tick |
| White – British |  | White & Black African |  | Pakistani |  | African |  |
| White – Irish |  | White & Asian |  | Bangladeshi |  | Any other background |  |
| White – Any Other |  | Any Other Mixed Background |  | Any other Asian background |  | Chinese |  |
| White & Black Caribbean |  | Indian |  | Caribbean |  | Any other ethnic group |  |
|  |  |  |  |  |  | Not stated |  |

Please send to CSH Single Point of Access (SPA)

Email: [CSH.SPAreferrals@nhs.net](mailto:CSH.SPAreferrals@nhs.net)

Tel: 0330 726 0333

Website:[www.cshsurrey.co.uk](http://www.cshsurrey.co.uk/)

SPA Opening Hours: (Monday-Friday: 8am - 6pm)