EAST RIDING PAEDIATRIC NUTRITION AND DIETETICS SERVICE REFERRAL FORM

PLEASE NOTE: ***Incomplete forms will be returned***.
Please email to: hnf-tr.humberpaediatricdietetics@nhs.net

The Dietetic service for the East Riding of Yorkshire will provide the following:

- **Non-complex non-IgE mediated food allergies**
- **Faltering Growth**
- **Weight management** - only if there are:
  - Comorbidities
  - Safeguarding or Child Looked After
  - Under 2 years of age
- **Irritable Bowel Syndrome** – diagnosed
- **Enteral Feeding**
  - East Riding GP and are under a non-HUTH consultant
  - Stable not requiring specialist MDT input
- **Coeliac disease**
  - East Riding GP and are under a non-HUTH consultant
- **Avoidant Restrictive Food Intake Disorder (ARFID)** – Only as part of MDT care
- **Nutrition Support**
  - Confirmed nutritional deficiency
  - Safeguarding or Child Looked After
  - Cerebral Palsy requiring oral nutritional supplements
  - Underweight requiring food fortification and/or oral nutritional supplements
- **Selective eating with**
  - Confirmed nutritional deficiencies
  - Weight is more than 2 centiles below height centile and/or height has plateaued for >3 months
  - and/or loss of height centiles
  - <5 foods from 1 – 2 food groups

Consent discussed and obtained? Yes ☐ / No☐ Parent/Carer/Young Person:

Consent for mobile phone texts/email and video call? ☐ Yes ☐ No

Referrer Details	
Print Name:	Job Title:
Address (workplace):	Signed: Note - student referrals to be countersigned by supervisor
Tel No:	Date:

Child/Young Person Details		
Child/Young Person Full Name: Preferred Name:	NHS Number: Date of Birth:	
Accommodation type: Address (inc. Post code):	Gender (at birth):	Gender identity:
	Language:	Interpreter needed: ☐ YES ☐ NO
	Ethnicity:	Religion:
	Sexuality:	Marital status:
Name of parents/carers:	Member of military family:	
Contact Numbers:	Email address:	

Any other diagnosis/relevant medical history:		
Disability:		
Any reasonable adjustments for the session:		
General Practitioner (GP):		
GP Name:	GP Tel No:	GP Email Address:
GP Address:		
School Details		
School Information:	Contact Number:	Email Address:
SENco details:	EHCP plan: ☐ Yes ☐ No	
Supporting information:		
Child Looked After (CLA): ☐ Yes ☐ No Is there a lone working risk? ☐ Yes ☐ No	Is there a safeguarding risk? ☐ Yes ☐ No Are there any historical safeguarding concerns? ☐ Yes ☐ No	
If yes, please provide further details:		

Details of any other service involvement - Current or historical		
CAMHS (including eating disorders team) ☐	Portage ☐	Educational Psychology ☐
Youth Offending Team ☐	Early Help ☐	Speech and Language ☐
Consultant/Paediatrician ☐	Sensory Processing Hub ☐	Other:
If yes, to any of the above please provide further details:		

Reason for referral	
☐**Faltering Growth** ☐**Feeding difficulties** ☐ **Weight management** - only if there are: - Comorbidities - Safeguarding or Child Looked After - Under 2 years of age ☐ **Irritable Bowel Syndrome** - diagnosed ☐**Enteral Feeding** - East Riding GP and are under a non-HUTH consultant - Stable not requiring specialist MDT input ☐**Coeliac disease** - East Riding GP and are under a non-HUTH consultant ☐**ARFID** – Only as part of MDT care	☐ **Nutrition Support** - Confirmed nutritional deficiency - Safeguarding or Child Looked After - Cerebral Palsy requiring oral nutritional supplements - Underweight requiring food fortification and/or oral nutritional supplements ☐**Selective eating only** with - Confirmed nutritional deficiencies - Weight is more than 2 centiles below height centile - and/or height has plateaued for >3 months - and/or loss of height centiles - <5 foods from 1 – 2 food groups* **Please complete sections 1 & 2*** ☐ **Non-complex non-IgE mediated food allergies** **Please complete section 3***

Anthropometrics		
Weight: (kg)	Weight centile	Date Obtained
Height: (metres):	Height centile	Date Obtained:
Has the weight and/or height centiles had a 2 centile drop in the last 3 months? ☐ Yes ☐ No		

Section 1 - How many foods from these food groups do they eat?

(Please add as much detail as possible)

Food Groups	**Yes/No**	**Please list all foods eaten in each group**
Fruit and Vegetables	Yes/No	
Carbohydrates e.g. Bread, rice, pasta, cereal etc.	Yes/No	
Protein e.g. meat, poultry, eggs, beans & pulses	Yes/No	
Dairy & Alternatives e.g. milk, cheese, yoghurt	Yes/No	
Fats & Oils e.g. butter, oil, margarine, mayonnaise.	Yes/No	

Section 2

Are there any known micro-nutrient deficiencies? ☐ Yes ☐ No (If yes please detail)

Are they taking any supplementation?

Oral nutritional supplement - ☐ Yes ☐ No If yes, please detail	Multivitamins - ☐ Yes ☐ No If yes, please detail

Describe current concerns around eating where possible, specify function for avoidance of food e.g. fear based, sensory, lack of interest.

Are there any relevant social or psychiatric history effecting food intake? ☐ Yes ☐ No (If yes please detail)

Have they received any professional support around eating or have any strategies been tried to help improve eating? ☐ Yes ☐ No (If yes please detail)

Can you provide a brief history of eating (including when potential issues around food/eating started).

Section 3 – Allergy Referral

Suspected food allergy (e.g. Milk, Soya, Egg etc):

Breastfeeding ☐Yes ☐ No	Formula feeding ☐ Yes ☐ No	Combination feeding ☐ Yes ☐ No

Allergy Formula prescribed ☐ Yes ☐ No Name of Formula:

Onset of symptoms: 0 – 2 hours (IgE mediated) ☐ 2 + hours (non-IgE mediated) ☐

Symptoms – Please tick

☐Irritability	☐Vomiting/Reflux	☐Food refusal	☐Diarrhoea
☐Blood and/or mucus in stools	☐Skin Pruritus (itching)	☐Erythema (flushing)	☐Angioedema
☐Abdominal discomfort	☐Constipation	☐Atopic dermatitis	☐Faltering Growth

Supporting Information