**DIETITIAN REFERRAL AUTHORISATION**

**FROM: Date:**

**Your Organisation:**

**Your Address:**

**Your Phone number :**

**Your Fax number: Number of Pages:**

**Sender:**

Nutrition Professionals Australia (NPA) is requested to review the following consumer:

Name… …………… …………………………………………………□ Site visit □ Remote Review □ Home visit

Address (If relevant)… ………………………………………………

Phone No (if Relevant) ………………………………………………

NPA will make an appointment time an Accredited Practising Dietitian to review the consumer.

Best practice and evidence based guidelines will be used when making recommendations for care.

All dietitians have $10m professional indemnity insurance, a current police check, Flu and COVID vaccinations.

The dietitian will attend your site or visit the individual in their home.

Following the appointment the dietitian will write a written report and meal plan where relevant and will provide this back to the individual/ your organisation/ medical practitioner as appropriate.

Where a remote review is required, access to the electronic medical record is preferable. A phone or teleconference call with an appropriate staff member and/ or the consumer will be required.

Review appointments will be scheduled as negotiated and as clinically indicated.

Please complete the details below including your signature and the details regarding the individual on the attached 2 pages if relevant.

Please then return all pages to NPA by return fax: 08 8227 1200 or email: admin@npagroup.com.au.

**Authorised by:**

Name (please print): ……………………………………………………

Signature: ..………………………………………………

Position:

Date: …………………………….

Funded by:□ Aged Care Home □ Client □ NDIS □ DVA

**DIETITIAN REFERRAL FORM**

**REASON FOR REFERRAL:**

|  |
| --- |
| **Name: DOB:** |
| **Appointment time:** |
| **Reason for referral:**  □ Weight loss  Please specify: ……………kg in 1 month  …………....kg in 3 months  ……………kg in 12 months  □ Diabetes (Type 1/ Type 2)  Insulin? Yes / No  □ Weight gain  Please specify: ……………kg in 1 month  …………....kg in 3 months  ……………kg in 12 months  □ Dysphagia  Diet Type:  Easy to Chew / Soft and Bite Sized / Minced and moist/ Puree/ Liquidised  □ Thickened fluids:- □ Mildly Thick □ Moderately Thick □ Extremely Thick    □ Enteral feeding (PEG)  □ Allergy or intolerance  Please specify ………………………………………  □ Other |
| Issues affecting appetite/ dietary intake/ requirements/ nutrition etc: |

**ADDITIONAL INFORMATION:**

Some of this information may be accessed directly from the consumer’s charts or clinical notes or care plans. Please fill in if this information is not available readily eg home visit)

|  |
| --- |
| **Name: DOB:** |
| **Height: (Or Ulna length)** |
| **Medical History:** |
| **Speech Pathology report (if applicable):**  (Please attach the most recent report) |
| **Medications:**  (Please attach if insufficient room provided) |
| **Relevant blood tests**  (Please attach) |
| **Bowel habit:**  🞏 Diarrhoea 🞏 Normal 🞏 Constipation |
| **Mobility:**  🞏 Fully mobile 🞏 Uses frame 🞏 Wheelchair 🞏 Chair or bed bound |
| **Use of oral nutrition supplements:** |