

Dietitian Referral Form Continuing Care

SEND REFERRAL TO:

Care Home Name & Location:						
Diagnosis:						
Height:	cm	Current Weigh	it: kg (Date:)		
Diet: 🗆 Regular	🗆 Textu	re Modified:		□ Other:		
Fluids: 🗆 Thin	🗆 Mildl	y Thick/Nectar	□ Moderately Thick/Honey	□ Extremely Thick/Pudding		
Nutritional Supp	lements (if applicable):				

High Nutrition Risk:	Moderate Nutrition Risk:					
Addressed (via phone, email or visit) within	Addressed (via phone, email or visit) within one month					
five working days						
Difficulty swallowing, difficulty chewing or	r 🛛 New admission with any of the following:					
recent aspiration pneumonia.	Texture modified diet					
(i.e. coughing or choking at meals, gurgly	\Box A BMI less than 18 (BMI = kg/m ²)					
voice before or after intake, watery eyes,	☐ At high risk of pressure ulcers					
nasal discharge, drooling, pocketing of						
food, etc.)	Recent change in diet texture. Specify reason for change:					
Please send Speech Language Pathology						
(SLP) consult if available in your area	□ Unplanned weight loss of 2.3 to 5 kg (5 to 11 lbs) in last					
	three months – confirm weight loss with one re-weigh					
Unplanned weight loss of greater than	three months - commin weight loss with one re weight					
5 kg/11 lb in the last three months or	New or delayed healing stage 2 pressure wound					
greater than 3.4 kg/7.5 lb in last month -	Drinking less than six cups of fluid per day for one week					
confirm weight loss with one re-weigh						
New or delayed healing stage 3 or 4	Eating less than 25% of most meals for one week or					
pressure wound	less than 50% for two weeks excluding end of life residents					
	Diet order that is causing significant restrictions (i.e. food					
□ Tube feed – new start or concerns (i.e.	allergies gluten free renal low fat etc.)					
diarrhea, constipation, emesis, abdominal						
distention, uncontrolled blood sugars,	Diabetes Management					
etc.)	New diagnosis					
Additional comments or other concerns not listed above:						
Date Print Name	Signature					
Referral source: doctor nurse resident resident's family other:						
Dietitian follow up date:						