Dietitian Referral Form For Nursing Home Residents

FRESENIUS KABI

Resident Name	
Resident Date of Birth	
Nursing Home name	
Name of referrer and job title	
Date of referral	
Telephone number	
Email address	

Consent
Please select as appropriate:

- ☐ The resident has consented to this referral
- ☐ The referral has been made in the resident's best interests

Medical History	
Reason for Dietetic referral	
Current clinical status: acute disease/recent infection or clinically stable (please specify)	

Is the resident receiving end of life care?	☐ Yes	☐ No
Has ceiling of care been discussed with the patient?	☐ Yes	☐ No
Is this resident a potential candidate for an enteral feeding tube?	☐ Yes	☐ No

Skin integrity	☐ Intact	☐ Pressure ulcer*	☐ Other*

*Please specify area and grade (if applicable):

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Unit 3B Fingal Bay, Balbriggan, Co. Dublin, Ireland
www.fresenius-kabi.ie
IE-HCP Act-2500002.
Date of Preparation: September 2025

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caring for life

Current diet and fluid regimen Method of intake:	☐ Oral feeding/drinking	☐ Enteral tube feeding	☐ Enteral Tube Feeding + Oral Diet

Has the patient's food intake recently reduced?	☐ Yes*	☐ No

*If Yes, please supply further details:

Please attach a completed food and fluid chat (download chart from www.clinicalnutrition.ie) and a current medications list.

Any nausea/vomiting?	
Mobility level	
Recent abnormal biochemistry	
Blood sugars (if applicable)	
Bowel motility	

Current swallow assessment recommendations

☐ Never previously assessed

If previously assessed: Speech & Language therapist name: Date:

FOOD*	LIQUID*
☐ **Level 7:** Regular	☐ **Level 0:** Thin
☐ **Level 7a:** Easy to Chew	☐ **Level 1:** Slightly Thick
☐ **Level 6:** Soft and Bite-Sized	☐ **Level 2:** Mildly Thick
☐ **Level 5:** Minced and Moist	☐ **Level 3** Moderately Thick
☐ **Level 4:** Pureed	☐ **Level 4:** Extremely Thick
☐ **Level 3:** Liquidised	

* Based on IDDSI (International Dysphagia Diet Standardisation Initiative). www.iddsi.org.

Weight History

Weight History	Weight (kg)	BMI (kg/m²)	MUST score
Current			
Last month			
3 months ago			
6 months ago			

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Dietary requirements:

☐ None ☐ Lactose intolerant ☐ Diabetic ☐ Nut allergy ☐ Fortified diet ☐ Coeliac Disease ☐ Other

Please provide details of prescribed oral nutrition supplements (ONS) (if applicable) and document how much of each they are managing:	
If patient is being enterally tube fed please document feed name, volume, rate and hours of feed:	

By sending this referral I understand:

- The resident (or referrer if the resident is unable to give informed consent) understands & acknowledges that their personal information will be securely used, stored and shared in order to provide ongoing clinical care.
- The information obtained by this form will be used for the purposes of therapeutic assessment only and will not be used by any other party. For more information on how we use this data please click here.
- Incomplete referrals will be returned and may delay assessment time.
- Assessments may be carried out remotely or in house by an independent healthcare professional as decided by the healthcare professional following triage of the referral.
- This is not an emergency service.
- This form must be received at least 48hrs prior to a planned Dietetic visit or the resident may not be assessed. I confirm this resident meets one or more of the below criteria for dietetic referral and I accept that inappropriate referrals will not be accepted:
  - MUST Score ≥ 2
  - Enteral Tube feed review
  - Change in swallow requirements requiring ONS change
  - Ongoing weight loss despite oral nutritional supplement
  - Wound healing
  - Other: please specify

Referrer Signature: Date:

Please review the form before signing.

PRINT FORM

Save this form and send it to:
dieteticreferrals@fresenius-kabi.ie

SAVE AND SEND FORM

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