**West Hampshire Enteral Nutrition Service (WHENS)**

**epartment Title**

First address line

Second address line

Third address line

Fourth address line

Postcode

Tel: 000 0000 0000

Fax: 000 0000 0000

Insert web address here

**Referral Form**

|  |  |
| --- | --- |
| **Patient Information** | |
| **Patient name:** |  |
| **Date of birth:** |  |
| **NHS Number:** |  |
| **Hospital number:** |  |
| **Address:** |  |
| **Primary telephone:** |  |
| **Email:** |  |
| **NOK or carer details: (if not self caring)** |  |

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| --- | --- |
| **GP Information** | |
| **GP surgery:** |  |
| **Address:** |  |
| **Telephone:** |  |

|  |  |
| --- | --- |
| **Medical History** | |
| **Diagnosis / indication for tube feeding:** |  |
| **Relevant medical history:** |  |
| **Medications: (include route and preparations)** |  |
| **Allergies:** |  |

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| --- | --- |
| **Enteral Feeding** | |
| **Feeding tube: (type of tube, size, insertion date and tube care details)** |  |
| **Ancillaries:** |  |
| **Plan for tube replacement:** |  |
| **If BGT, is patient suitable for Enplugs?** |  |
| **Feeding regimen:**  **Feed:**  **Rate / start time:**  **Water flushes:**  **Total fluid:** |  |
| **Feed prescription sent to GP:** | **Please tick once completed** |
| **Nutricia training requested / completed:** |  |
| **Current pump serial number: (if applicable)** |  |
| **Oral intake and IDDSI level:** | **Fluids:**  **Diet:** |
| **Likely to progress with oral intake?** |  |
| **Nutritional status: (please include dates)**  **Weight:**  **Height:**  **BMI:**  **Method of weighing:** |  |
| **Aims of treatment:** |  |

|  |  |
| --- | --- |
| **Other Information** | |
| **Additional communication needs?**  **If yes, please provide information:** | **Yes  No** |
| **Any other relevant information: (alerts, covid vaccination, mobility, social history, access to property, pets)** |  |

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| --- | --- |
| **Discharge Information** | |
| **Discharge from location:** |  |
| **Date due for discharge:** |  |
| **Care arrangements / care agency:** |  |
| **If being discharged to a care home, have the staff had training?** |  |
| **Referring dietitian name:** |  |
| **Department:** |  |
| **Telephone:** |  |
| **Email:** |  |
| **Please give details if patient will be reviewed again at the hospital:** |  |

**Once form has been completed, please email to:**

[whens@southernhealth.nhs.uk](mailto:whens@southernhealth.nhs.uk)

**Please call 0300 003 0199 for any enquiries**

**\*For internal use only**

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| --- | --- |
| **Assigned HCP:** |  |
| **Patient added to caseload:** |  |
| **Form(s) uploaded to RIO:** |  |
| **First contact appointment: (5 days)** |  |
| **Registered on Nutricia?** |  |
| **For enteral feeding / planned future care:** |  |
| **Nursing care only?** |  |
| **Complete enteral feeding assessment:** |  |