For Office Use Only
Ref No:

NHS Islington
NHS Camden

SELF REFERRAL FORM FOR NUTRITION AND DIETETIC SERVICE

Title: Mr / Mrs / Ms / Miss / Dr / Other (please circle which you prefer) male/female

Client's Last name*:_____ Client's First name*: _____

Date of Birth*:_____/_____/_____

Address*: _____

_____ Postcode*:_____

Telephone number*: _____

Mobile / day time telephone number*: _____

E-mail address: _____

Preferred method of contact: Telephone ■ Mobile ■
E-mail ■ Letter ■

What is your ethnic origin? _____
What is your first language? _____
Do you require an interpreter? _____

Name of General Practitioner (GP)* _____

Address of Practice*: _____

We will usually contact your GP to inform them of ongoing treatment and check we are providing you with tailored advice. Please confirm your acceptance.
Yes ■ No ■ (please note refusal may limit self referral treatment options)

Reason for Dietitian appt*_____

What do you expect to get out of your appointment?

_____
_____
_____
_____

Current Weight:_____ Current Height: _____

Body Mass Index (BMI) if known: _____

Can you please tell us how you heard about us? _____

Please return to: ARTI, NHS Islington, Ground Floor, 338-346 Goswell Road, London EC1V 7LQ or fax: 0844 774 6419 or email: arti.centralbooking@nhs.net
Lines marked with an asterix * are mandatory and must be completed. Incomplete forms will be returned.

Any medical conditions should be made known in order to ensure appropriate care. Please fill in the medical questionnaire below. Completed Yes ■ No ■

Please tick (YES or NO) in response to ALL the conditions/statements listed:

Do you currently have or have you ever suffered with any of the following, if YES please give details

Allergy (clinical diagnosis)	YES ■	NO ■	detail _____
Anorexia Nervosa	YES ■	NO ■	detail_____
Asthma	YES ■	NO ■	detail_____
Bulimia Nervosa	YES ■	NO ■	detail_____
Chronic Obstructive Pulmonary Disease	YES ■	NO ■	detail_____
Crohn's disease	YES ■	NO ■	detail_____
Coeliac's Disease	YES ■	NO ■	detail_____
Constipation	YES ■	NO ■	detail_____
Diabetes	YES ■	NO ■	detail_____
Diarrhoea	YES ■	NO ■	detail_____
(Essential) Hypertension	YES ■	NO ■	detail_____
Inflammatory Bowel Disease	YES ■	NO ■	detail_____
Irritable Bowel Syndrome	YES ■	NO ■	detail_____
Nausea or vomiting	YES ■	NO ■	detail_____
Heart problems	YES ■	NO ■	detail_____
Kidney disease	YES ■	NO ■	detail_____
Mental Health Conditions	YES ■	NO ■	detail_____
Sleep Apnoea	YES ■	NO ■	detail_____
Stroke	YES ■	NO ■	detail_____

Please record most recent blood results linked to your conditions (if known):
Total cholesterol:_____HDL:_____LDL:_____Triglycerides: _____

Fasting blood sugar:_____ HbA1c_____

Are you on any medications? Yes ■ No ■
If yes please list or attach prescription print off: _____

Are you able to travel to clinic? Yes 7 ■ No ■
If no, please give reason:
If yes 7 Do you need transport? _____

I declare that this information is correct to the best of my knowledge

Your signature OR signature of parent/guardian for under 18's*:_____

PRINT NAME*:_____ **DATE:**_____

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