

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 <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Anorexia Nervosa	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Asthma	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Bulimia Nervosa	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Chronic Obstructive Pulmonary Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Crohn's disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Coeliac's Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Constipation	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Diarrhoea	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
(Essential) Hypertension	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Inflammatory Bowel Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Irritable Bowel Syndrome	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Nausea or vomiting	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Heart problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Kidney disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Mental Health Conditions	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Sleep Apnoea	YES <input type="checkbox"/>	NO <input type="checkbox"/>	detail _____
Stroke	YES <input type="checkbox"/>	NO <input type="checkbox"/>	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 No

If no, please give reason:

If yes 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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