Community Dietetic Gastroenterology Service

Self Referral Form – for Adults Only

Somerset NHS Foundation Trust

PLEASE NOTE: We can only see patients with a **GP in Somerset**.

Somerset NHS Foundation Trust's Community Dietetic Gastroenterology Service provides specialist advice to help people who suffer with intractable irritable bowel syndrome. This referral form should be completed if you are still suffering from significant symptoms two months after implementing the first line dietary advice recommended within the previously sent pack, or via the webinar (www.patientwebinars.co.uk).

Name:		**Date of Birth:**	
NHS Number (if known):			
Address:		**Email:**	
Mobile Number:		**Land Line Number:**	
GP Name & Address		**Date Form Completed:**	

1. In one sentence, please state what you would like to achieve by seeing a gastroenterology dietitian:

2. Which condition are you being referred to the dietitian for dietary advice for?
(Tick all that apply)

	Office Use Only		*Office Use Only*
☐ Irritable Bowel Syndrome (IBS)	1	☐ Coeliac Disease	6
☐ Diverticular Disease	2	☐ Food Allergy – if so to which food	7
☐ Constipation	3	……	
☐ Inflammatory Bowel Disease (Active Disease)	4	☐ Other (Please state)	8
☐ Inflammatory Bowel Disease (In Remission)	5	……..	

Symptom Review

3. Please tick the number of years you have suffered with your gut/bowel symptoms:
(Please tick ONE box)

Office Use Only		*Office Use Only*

☐ Under 1 year	1	☐ 11-15 years	4
☐ 1-5 years	2	☐ 16-20 years	5
☐ 6-10 years	3	☐ Over 20 years	6

4. Do you currently have satisfactory relief of your gut symptoms? (Please tick ONE box)

☐ Yes ☐ No

5. Please rate your symptoms during the last week by placing a tick in the box that best describes each symptom. (Please tick 'none' if you do not have this symptom)

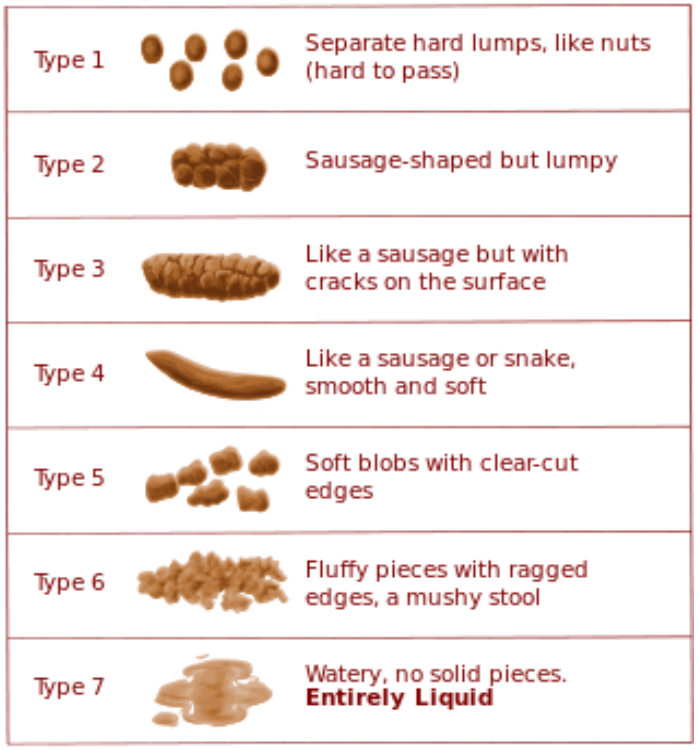
	No symptoms or very rarely	Occasional or mild symptoms	Frequent symptoms that affect some social activities	Continuous symptoms that affect most social activities
	NONE (0)	**MILD (1)**	**MODERATE (2)**	**SEVERE (3)**
Abdominal pain / discomfort				
Abdominal bloating / distention				
Increased wind / flatulence				
Belching / burping				
Gurgling noises from stomach / abdomen				
Urgency to open bowels				
Incomplete evacuation (feeling of inability to pass all of a stool)				
Nausea / feeling sick				
Heartburn				
Acid Regurgitation				
Tiredness				
Overall Symptoms				

6. Currently, how often do you pass a bowel action? (Please tick ONE box)

	Office Use Only		*Office Use Only*
☐ Once a week	1	☐ 2-3 times per day	5
☐ Once every 4-6 days	2	☐ 4-6 times per day	6
☐ Once every 2-3 days	3	☐ 7 or more times per day	7
☐ Once a day	4		

7. Please tick the boxes that best describe your current stool:
(If more than one tick, please state how often for each)

Bristol Stool Chart



Medical History

8. How many times <u>in the last 1 year</u>, have you seen your GP in relation to your gut symptoms? (Please tick ONE box)

	Office Use Only		*Office Use Only*
☐ None	0	☐ 7 - 9 times	3
☐ 1 - 3 times	1	☐ 10 or more times	4
☐ 4 - 6 times	2		

9. Have you seen a gastroenterologist <u>in the last 1 year</u> in relation to your gut symptoms?
(Please tick ONE box)

☐ Yes ☐ No

If Yes, how many times have you seen the gastroenterologist in the last year…….

10. Have you had any of the following tests in the last 12 months?

Blood test to rule out Coeliac Disease	☐ Yes	☐ No	**If NO, please request one from your GP surgery**
Faecal Calprotectin stool sample test	☐ Yes	☐ No	**If NO, then please DO NOT request this test – we can discuss whether this is relevant at your appointment**

11. What is your current weight and height?

Current weight:

Height:

12. Have you experienced any unintentional weight loss within the last 12 months, and if so, how much?

13. Do you have any other past medical history that we should be aware of? (Including both physical and mental health conditions)**:**

14. Do you have any of the following? (Please tick all that apply)

Blood in your stools	☐ Yes	☐ No
Unintended weight loss of more than 1 stone	☐ Yes	☐ No
Unexplained anaemia or low iron levels	☐ Yes	☐ No
Family history of ovarian or bowel cancer	☐ Yes	☐ No
Do your gut symptoms regularly wake you up at night	☐ Yes	☐ No

If you have ticked 'yes' to any of the questions in section 14 above, please ensure that you have discussed these symptoms with your GP before attending this clinic for dietary advice.

15. Have you been diagnosed with an eating disorder in the past?

☐ Yes ☐ No If 'yes' please specify

16. Do you have a history of previous abdominal surgery?

☐ Yes ☐ No If 'yes' please specify

17. Have you ever suffered with the following conditions as either a child or an adult? (Please tick all that apply)

Condition	***Mild***	***Moderate***	***Severe***
Hay fever	☐	☐	☐
Asthma	☐	☐	☐
Eczema	☐	☐	☐
Food allergy (diagnosed by a medical professional)	☐	☐	☐
Milk allergy (diagnosed by a medical professional)	☐	☐	☐
Lactose intolerance (diagnosed by a medical professional)	☐	☐	☐
Any other allergies, e.g. animal, hair, house dust mite	☐	☐	☐

18. Do you currently use any prescribed or over the counter medications for your gut symptoms? (Please tick ONE box)

☐ Yes ☐ No

If yes, please state which ones.....

Dietary Information

19. Are you following any specific diets at the moment, in an attempt to manage your gut symptoms? (Please tick ONE box)

☐ Yes ☐ No

If yes, please state which ones.....

20. What dietary changes have you already tried to help manage your gut symptoms? (Please tick all that you have tried)

	Office Use Only		*Office Use Only*
☐ Altering fibre intake	0	☐ Low lactose diet	5
☐ Increasing fluid intake	1	☐ Dairy free diet	6
☐ Reducing processed foods	2	☐ Gluten free diet	7
☐ Reducing caffeine intake	3	☐ Low FODMAP diet	8
☐ Reducing fat intake	4	☐ Other – please state: ……...	9

21. Please tick any webinars that you have attended on our NHS website www.patientwebinars.co.uk.

☐ IBS First Line Advice	☐ Low FODMAP Diet	☐ Diverticular Disease
☐ Low Lactose Diet	☐ Constipation	☐ Reflux

Other (Please state) _____

22. Please answer the following questions to help us understand the impact that your symptoms are having on your current diet and food-related quality of life: (Please tick ONE box for each question)

a) How often do you find that your gut symptoms cause you to avoid eating when you are hungry?

	Office Use Only		*Office Use Only*
☐ None of the time	0	☐ A good bit of the time	3
☐ A little of the time	1	☐ Most of the time	4
☐ Some of the time	2	☐ All of the time	5

b) Do you avoid certain foods or drinks due to your gut symptoms?

	Office Use Only		*Office Use Only*
☐ None of the time	0	☐ A good bit of the time	3
☐ A little of the time	1	☐ Most of the time	4
☐ Some of the time	2	☐ All of the time	5

c) How often does food seem unappealing because of your gut symptoms?

	Office Use Only		*Office Use Only*
☐ None of the time	0	☐ A good bit of the time	3
☐ A little of the time	1	☐ Most of the time	4
☐ Some of the time	2	☐ All of the time	5

Other Factors

We would like to know if there are any psychological elements that might be affecting you. Are you happy to answer questions to assess any psychological impact? (Please note this is just for our assessment and the answers you give will not affect the care you are given)

☐ Yes ☐ No – prefer not to answer

The questions in this scale ask about your feelings and thoughts during the last month. For each question tick the option that best describes how you felt. The best approach is to answer fairly quickly. That is, don't try to count the number of times you felt a particular way; rather indicate the option that seems like a reasonable estimate.

Office Use Only

0	1	2	3	4

1. In the last month, how often have you been upset because of something that happened unexpectedly?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

2. In the last month, how often have you felt that you were unable to control the important things in your life?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

3. In the last month, how often have you felt nervous and stressed?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

4. In the last month, how often have you found that you could not cope with all the things that you had to do?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

5. In the last month, how often have you been angered because of things that happened that were outside of your control?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

6. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

Office Use Only				
4	3	2	1	0

7. In the last month, how often have you felt confident about your ability to handle your personal problems?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

8. In the last month, how often have you felt that things were going your way?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

9. In the last month, how often have you been able to control irritations in your life?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

10. In the last month, how often have you felt that you were on top of things?

never	almost never	sometimes	fairly often	very often
☐	☐	☐	☐	☐

Thank you for completing this form.

What happens next?
Once you have completed this form, please send it via post or email using the information below. Once received, we will contact you to arrange an appointment with one of our gastroenterology dietitians.

Post to:
Somerset Community Dietitians, 1st Floor, Bridgwater House, King Square, Bridgwater, Somerset, TA6 3AR

Please note that this is a correspondence address only. Please do not hand return self-referral forms to this address, as we cannot guarantee that it will safely reach us. We thank you for your understanding.

Email to*:
dieteticsreferrals@somersetft.nhs.uk

*Please note that using public email services is not secure and Somerset NHS Foundation Trust cannot accept responsibility for any email correspondence until it reaches us. We will send you acknowledgement to confirm receipt of your email. You may wish to consider sending your email encrypted. If you are in any doubt about sending your form by email, then you should post this to us at the address at the top of this self-referral form.

If you have any questions or need help completing this form, please contact the dietetic department on 01278 447407. If you do not send this form back, we will assume you do not need dietetic support at this time, therefore no further action will be taken.

We would welcome any feedback on your experience of accessing this service and using this form in order to improve our service. Please send any comments to the address above. Thank you.