# 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:** | |
| **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 state for how long you have suffered with your gut/bowel symptoms:**

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. Which symptom(s) MOST affect your quality of life?**

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

| | Office Use Only | | Office Use Only |
|---|---|---|---|
| ☐ Once a week | 0 | ☐ 2-3 times per day | 4 |
| ☐ Once every 4-6 days | 1 | ☐ 4-6 times per day | 5 |
| ☐ Once every 2-3 days | 2 | ☐ 7 or more times per day | 6 |
| ☐ Once a day | 3 | | |

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

## Bristol Stool Chart

| | | |
|---|---|---|
| Type 1 |  | Separate hard lumps, like nuts (hard to pass) |
| Type 2 |  | Sausage-shaped but lumpy |
| Type 3 |  | Like a sausage but with cracks on the surface |
| Type 4 |  | Like a sausage or snake, smooth and soft |
| Type 5 |  | Soft blobs with clear-cut edges |
| Type 6 |  | Fluffy pieces with ragged edges, a mushy stool |
| Type 7 |  | Watery, no solid pieces. **Entirely Liquid** |

## Medical, Surgical and drug history

**9. 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 | | |

**10. 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…….

**11. Which investigations have you had <u>in the last 1 year</u> in relation to your gut symptoms?**
(Please tick all that apply)

| | *Office Use Only* | | *Office Use Only* |
|---|---|---|---|
| ☐ None | 0 | ☐ Ultrasound | 7 |
| ☐ Blood tests | 1 | ☐ Barium enema/meal | 8 |
| ☐ Stool Sample | 2 | ☐ Breath Tests | 9 |
| ☐ Gastroscopy | 3 | ☐ CT Scan | 10 |
| ☐ Colonoscopy | 4 | ☐ MRI Scan | 11 |
| ☐ Sigmoidoscopy | 5 | ☐ Other – please state: …….. | 12 |
| ☐ Virtual/Capsule Colonoscopy | 6 | …… | |

**12. 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** |

**13. What is your current weight and height?**
Current weight:
Height:

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

**15. 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.**

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

**17. Have you been diagnosed with an Eating Disorder in the past?**

☐ Yes ☐ No If 'yes' please specify

**18. Do you have a history of previous abdominal surgery?**

☐ Yes ☐ No If 'yes' please specify

**19. 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 | ☐ | ☐ | ☐ |

**20. 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

**21. Are you following any specific diets at the moment, in an attempt to manage your gut symptoms?** (If yes, please tick the diets you are currently following below):

| | *Office Use Only* | | *Office Use Only* |
|---|---|---|---|
| ☐ Low Lactose diet | 0 | ☐ Vegan diet | 5 |
| ☐ Gluten Free diet | 1 | ☐ Vegetarian diet | 6 |
| ☐ Low FODMAP Diet | 2 | ☐ Other – please state: | 7 |
| ☐ Dairy Free diet | 3 | …….. | |
| ☐ Low Carbohydrate Diet | 4 | | |

**22. 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 |

**23. Please tick any webinars that you have attended on our NHS website [www.patientwebinars.co.uk](http://www.patientwebinars.co.uk).**

☐ IBS First Line Advice ☐ Low FODMAP Diet Other (Please state) ☐ Low Lactose

**24. 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?**

☐ none of the time ☐ a little of the time ☐ some of the time
☐ a good bit of the time ☐ most of the time ☐ all of the time

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

☐ none of the time ☐ a little of the time ☐ some of the time
☐ a good bit of the time ☐ most of the time ☐ all of the time

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

☐ none of the time ☐ a little of the time ☐ some of the time
☐ a good bit of the time ☐ most of the time ☐ all of the time

## 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 offer you an appointment if appropriate.

**Post to:**
Community Dietitians, 2nd Floor, Nest @ Mallard, Bristol Road, Bridgwater, Somerset, TA6 4RN

**Or 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.**