



Paediatric Dietetic Restrictive Eating Self-Referral Form

Please	com	olete	all	sections
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Child's Name	DOB	
NHS Number (if known)		
Child's address And postcode		
Child's GP name a GP Name:		
GF Maille.	GP surgery:	
Referrer Details		
Name:	Relationship to child:	
Email address:	Mobile:	
	e webinars, what do you hope to achieve from a dietetic clinic/telephone appointmer	nt?
What dietary advic	e have you received in the past and how has this made a difference?	
In particular, what	does your child struggle with? Please detail the reasons.	

What are your main concerns about your child's eating or drinking?





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Please complete all sections

Does your child miss out foods from any of the main food groups? - fruit and vegetables, carbohydrates (eg bread and pasta), protein (dairy, meat, fish, soya)

How does your child respond to family meal times? Please give examples e.g. do they sit at the table, on the sofa, can the tolerate being in the same room as everyone else at mealtimes

How does your child feel about touching food / drink or having a messy face? Please give examples

Please also complete the separate FOOD DIARY and email/send the food diary along with this form. Referrals will not be accepted without a weight, height and completed food diary

IMPORTANT: Please return your completed form, to the following address:

Somerset Community Dietitians

1st Floor Bridgwater House

King Square

Bridgwater

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. 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 above.