Community Dietetic Gastroenterology Service

*Self Referral Form – for adults only*

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

**Please complete all the questions on the form and the attached 3 day diet history before returning the paperwork to our office. Details for return can be found on the final page of this form.**

**Part A: Personal Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of form completed |  | Date referral received (Office use) |  |
| Name |  | | |
| Date of birth |  | NHS No. |  |
| Address |  | Preferred telephone contact number |  |
| Email Address |  | Note: all email correspondence will be sent encrypted. | |
| Name of GP |  | GP Surgery |  |
| Name of Gastroenterologist (if known) |  | Name of Hospital where you were diagnosed with coeliac disease |  |

**Part B: Reason for Referral**

|  |
| --- |
| Please state what you would like to achieve by seeing the gastroenterology dietitian |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you currently experiencing any on-going symptoms related to your coeliac disease? | **Yes** |  | **No** |  |
| If you have answered **yes**, please state what symptoms you are experiencing. | | | | |

|  |  |  |
| --- | --- | --- |
| **Please answer the following questions:** | **Yes** | **No** |
| Do you have blood in your stools? |  |  |
| Have you had a recent onset of new gut symptoms? |  |  |
| Have you experienced any recent unexplained weight loss? |  |  |
| Do you wake at night regularly to open your bowels? |  |  |

**If you have answered ‘Yes’ to any of the above questions, please ensure you have discussed them with your GP or Gastroenterologist.**

**Part C: Background to referral**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| In what year were you diagnosed with Coeliac Disease? | |  | | | | |
| Why were you tested for Coeliac Disease?  (please tick all that apply) | | I had unexplained abdominal and gut symptoms | | | |  |
| I had symptoms suggestive of irritable bowel syndrome | | | |  |
| I had unexplained weight loss | | | |  |
| I was feeling tired all the time | | | |  |
| I had persistent mouth ulcers | | | |  |
| I had unexplained anaemia on blood tests | | | |  |
| I have other autoimmune conditions | | | |  |
| I have a relative with coeliac disease | | | |  |
| I have evidence of early bone loss (e.g. osteopenia, osteoporosis) | | | |  |
| I had unexplained symptoms related to the nervous system (e.g. balance problems, or numbness/tingling in hands/feet, repeated migraines) | | | |  |
| Other | | | |  |
| Cannot remember | | | |  |
| Did you have an endoscopy that included the taking of biopsies to confirm your diagnosis of Coeliac Disease? | | | **Yes** |  | **No** |  |
| After your diagnosis, did you see a dietitian to discuss the gluten free diet? | | | **Yes** |  | **No** |  |
|  | | | | | | |
| How long ago did you see the following healthcare professionals to discuss the management of your coeliac disease? | | | | | | |
| Dietitian | |  | | | | |
| Gastroenterologist | |  | | | | |
| GP | |  | | | | |
| Other Healthcare professional | |  | | | | |
|  | | | | | | |
| Please state any other medical conditions we should be aware of. | | | | | | |
|  | | | | | | |
| What is your… | Current Weight |  | | | | |
| Current Height |  | | | | |
| Weight 1 year Ago |  | | | | |

**Part C: Other Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Have you watched any of the webinars on our website [www.patientwebinars.co.uk](http://www.patientwebinars.co.uk)? | | | | **Yes** |  | **No** |  |
| If yes, please tick the ones you have watched? | | | | | | | |
|  | Newly Diagnosed Coeliac Disease |  | First Line Dietary Advice for IBS | | | | |
|  | Annual Review |  | Low FODMAP Diet | | | | |
|  | Bite-size webinars related to Coeliac Disease |  | Other | | | | |

**Please tick one answer to each of the following questions**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Score** | | | | | |
| **Question** | **1** | **2** | **3** | **4** | **5** | **Score** |
| Q1. Have you been bothered by low energy level during the past 4 weeks? | ☐  None of the  time | ☐  A little of the time | ☐  Some of the  time | ☐  Most of the time | ☐  All of the time |  |
| Q2. Have you been bothered by headaches during the past 4 weeks? | ☐  None of the  time | ☐  A little of the time | ☐  Some of the  time | ☐  Most of the time | ☐  All of the time |  |
| Q3. I am able to follow a Gluten Free Diet when dining outside my home | ☐  Strongly agree | ☐  Somewhat agree | ☐  Neither agree nor disagree | ☐  Somewhat disagree | ☐  Strongly disagree |  |
| Q4. Before I do something I carefully consider  the consequences | ☐  Strongly agree | ☐  Somewhat agree | ☐  Neither agree nor disagree | ☐  Somewhat disagree | ☐  Strongly disagree |  |
| Q5. I do not consider myself a failure | ☐  Strongly agree | ☐  Somewhat agree | ☐  Neither agree nor disagree | ☐  Somewhat disagree | ☐  Strongly disagree |  |
| Q6. How important to your health are accidental gluten exposures? | ☐  Very important | ☐  Somewhat  important | ☐  Neutral/ unsure | ☐  A little important | ☐  Not at all important |  |
| Q7. Over the past 4 weeks, how many times have you eaten foods containing gluten on purpose? | ☐  0 (never) | ☐  1–2 | ☐  3–5 | ☐  6–10 | ☐  More than10 |  |
| **Total Score**  **(should be between 7 and 35)** | | | | | |  |

**Part D: Bone Health**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Have you had a scan (known as a DEXA Scan) to check for bone loss? | | | **Yes** |  | **No** |  |
| If Yes… | How long ago was the scan? |  | | | | |
| Was the scan results ‘abnormal’? | | **Yes** |  | **No** |  |
|  | | | | | | |
| Are you taking… | Calcium Supplements? | | **Yes** |  | **No** |  |
| Vitamin D Supplements? | | **Yes** |  | **No** |  |

**Part E: Symptoms**

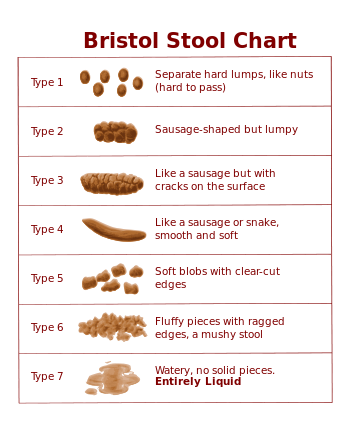
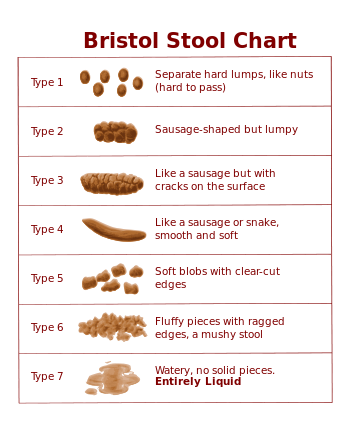
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you currently satisfied with the control of your symptoms related to coeliac disease? | **Yes** |  | **No** |  |

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 |  |  |  |  |
| Severe Headaches or Migraines |  |  |  |  |
| Foggy Head |  |  |  |  |
| Pins and Needles in Hands and/or Feet |  |  |  |  |
| Poor Balance |  |  |  |  |
| Overall Symptoms |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Currently, how often do you pass a bowel action? (please tick one option) | | | |
|  | Once a week |  | 2-3 times per day |
|  | Once every 4-6 days |  | 4-6 times per day |
|  | Once every 2-3 days |  | 7 or more times per day |
|  | Once a day |  | Variable |

|  |
| --- |
| Please circle the type which best describes your most common stool type |



**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](mailto: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.

Do you consent to us contacting you

via text message and/or email? Yes No

FOOD DIARY EXAMPLE SHEET

Please complete a record of all foods consumed, including quantities (see example below). This should be kept for 3 consecutive days including weekend days.

|  |  |  |
| --- | --- | --- |
| Name | Date of Birth | NHS Number |

|  |  |  |
| --- | --- | --- |
| Date | Type of Food or Drink | Quantity Taken |
| Breakfast | Gluten free (GF) cornflakes  Full cream milk  Goats milk yoghurt  GF toast (white bread)  Spread on toast (sunflower marg) | 3 Tbsp  85mls  2 Tbsp  1 Slice |
| Mid morning | Cup of tea (black)  milk chocolate bar | 200mls  60g (wt on packet) |
| Lunch | Rindless bacon grilled  chips in sunflower oil  baked beans (Tesco's own)  Drink of full cream milk | 3  10  3 Tbsp  200mls |
| Mid afternoon | Cup of tea (black) | 200mls |
| Evening meal | Chicken & vegetable Stir-fry (with onions, peppers, peas & leeks)  White basmati rice  Gluten Free Sweet Chilli Sauce  1 large glass white wine | 1chicken breast, ¼ onion. ½ pepper, tbsp peas, ¼ leek  4 Tbsp cooked  1 Tbsp  175mls |
| Evening/Bedtime | Hot chocolate made with full cream milk  Gluten Free Digestive Biscuit | 2 Tbsp chocolate powder, 110ml full milk  1 biscuit |
| Vitamin/mineral supplements and any other dietary supplements | Multivitamin and mineral supplement  Calcium (440mg/day) and vitamin D (10 /day) supplement |  |

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| Mid morning |  |  |
| Lunch |  |  |
| Mid afternoon |  |  |
| Evening meal |  |  |
| Evening/Bedtime |  |  |
| Vitamin/mineral supplements and any other dietary supplements |  |  |

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| Evening/Bedtime |  |  |
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