Department of Nutrition & Dietetics

**08/11/2017**

**Private and Confidential**

**GP/ Consultant Address**

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**Guy's Hospital**

Great Maze Pond

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*Clinic: 020 7188 4128*

*Main Switchboard: 020 7188 7188*

Dear Doctor

|  |  |
| --- | --- |
| **Reason for Referral** |  |
| **Nutritional Diagnosis** |  |
| **Medical/Surgical Diagnosis** |  |
| **Relevant Medications** |  |
| **Relevant Biochemistry/ Investigations** |  |
| **Nutritional Treatment +/-medical** |  |
| **Diet Therapy Outcome** |  |

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| **GP/Consultant/CNS/Other AHP Actions** |
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| **\*\*\*\*\*NUTRITION PRESCRIPTION REQUEST\*\*\*\*\*** | | | | | | | | | |
| Name & Manufacturer | Flavour | Volume (ml/g) per serve | Quantity  /serves per day | Total volume for 28days | Volume per pack | No. of packs required for 28 days | Duration (weeks) | Prescription Type | ‘Patient Information for Prescription |
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| **‘Pop Up’/Screen message for prescription** |
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| **Standard ACBS Indicator for Oral Nutritional Supplements (ONS) (BNF, 2015)** | |
| * Bowel Fistula * Continuous Ambulatory Peritoneal Dialysis * Disease- related Malnutrition * Dysphagia * Following Total Gastrectomy * Growth Failure | * Haemodialysis * Inflammatory Bowel Disease * Intractable Malabsorption * Pre-op preparation for undernourished patients * Short Bowel Syndrome |
| **Specific ACBs Indicator for ‘insert name’ supplement:** | |

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| **Summary of consultation** |
| Include details of consultation and reason for review. Include rationale for supplements particularly if BMI >18.5. Detail specific side effects of treatment which necessitate the dietary intervention |

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| **Resources/Education/Advice Provided** |
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| **Follow Up Arrangements** |
| \*\*EXAMPLES\*\*  **GP PLEASE REVIEW.** Please review the ongoing need for ONS by (DATE). Please discontinue ONS if diet therapy goals above have been achieved, arrange to repeat nutritional screening in 1 month. If goals have not been achieved please contact the dietitian (details below) or refer patient to the (insert name e.g. LAMP/Paediatric) community dietetic team.  OR  The patient will be seen in the community/acute setting by (name) (dietitian) on (date) Contact number:  OR  A further dietetic referral has been made to the (name) Community dietitians. They will arrange further follow up. Contact details: |

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| --- | --- | --- | --- |
| **Dietetic Supporting Information**  **Anthropometry** | | | |
| Weight (kg) : | Height (m) : | | BMI (kg/m²): |
| Weight History: | | | |
| Weight Change: | | Malnutrition Risk Score e.g. MUST Score: | |
| Other Anthropometry: | | | |

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| --- | --- |
| **Enteral feeding tube** | |
| **Type/ size** |  |
| **Date of Placement/ Removal Date** \*delete as applicable |  |
| **Enteral feeding regimen** | Delete if not appropriate |

Please do not hesitate to contact me should you require any further information.

Yours sincerely

*[FROM\_FirstName] [FROM\_LastName]*

*Dietitian*

*HCPC Number*

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Standard Operating Procedure (SOP)

**Dietetic Standard Letter**

Summary

*This SOP supports the whole GSTT dietetic team in writing letters to provide detailed written communication following a dietetic consultation. It provides clear guidance on information that should be provided when writing a dietetic letter. The SOP details information which is considered mandatory and as such should be included in all letters that are written by dietitians.*

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**Standard Operating Procedure**

**Dietetic Letter Template**

This document is designed to provide a step by step reference guide for completing the standard dietetic letter.

* Parts of the letter are mandatory and these will be identified with **red bold text.**
* Other boxes can be included or deleted depending on the nature of the letter and team preference. For example if no supplements are being prescribed the supplement box (BOX3) should be deleted.
* Please ensure that any boxes that are not relevant are deleted.

Below the boxes from the letter have been populated with example information. Within your teams you may wish to come up with individual standard phrases/ sentences.

**Box 1 Demographic Information**

|  |  |
| --- | --- |
| **Patient Name:** | **D.O.B** |
| **NHS Number:** | |
| **Address:** | |

This box will not be required if letter is being written on lettermaker (EPR)

**Box 2 Background Information**

|  |  |  |
| --- | --- | --- |
| **Reason for Referral** | | **Unintentional weight loss. Weight management Lipid lowering, IBS, IBD ETC**   * ***Teams to decide and populate own standard referral reasons*** * ***Aim to keep concise and within space provided*** |
| **Nutritional Diagnosis** | | **Chronic disease related malnutrition, evidenced by BMI<18.5kg/m2, as a result of (disease related signs and symptoms e.g. stroke with dysphagia)**  *-See information below for more guidance.* |
| **Medical/Surgical diagnosis** | | Optional. May insert information regarding patient’s medical diagnosis including treatment plan e.g Cancer staging and treatment plan/diagnosis of Coeliac disease and information regarding serology and/or duodenal biopsy  **\*\*\*\*\*Delete this row if not required\*\*\*\*\*** |
| **Relevant Medications** | | **\*\*\*\*\*Delete this row if not required\*\*\*\*\*** |
| **Relevant Biochemistry/ Investigations** | | **\*\*\*\*\*Delete this row if not required\*\*\*\*\*** |
| **Nutritional Treatment +/-medical** | | **Oral nutritional support. Enteral tube feeding. Food based interventions. Dietary education. Weight reduction.** |
| **Diet Therapy Outcome** | **Optimise dietary intake; maintain nutritional status; minimise nutritional losses; improve nutritional status pre-operatively.**   * ***Teams to decide and populate own diet therapy goals*** * ***Diet Therapy goals can be as specific or as broad as needed*** * *-See information below for more guidance.* | |

Further information for **Nutritional Diagnosis**

Information from the BDA Dietetic Care Process:

The nutritional diagnosis should include the following 3 components:

1. The Problem - Describes the alterations in the patient nutritional status.

2. Aetiology - The related factors are those factors contributing to the existence of, or maintenance of pathophysiological, psychosocial, situational, developmental, cultural, and/or environmental problems.

3. Signs/Symptoms - The defining characteristics are a cluster of subjective and objective signs and symptoms established for each nutritional diagnosis.

*e.g. Patient is malnourished (problem) due to reduced access to food through financial and social situation (Aetiology) as evidenced by BMI of 16kg/m2, clinically significant weight loss of 16% in four months and inadequate nutritional intake reported by patient (Signs/Symptoms)*

Further information for **Diet Therapy Outcome**

To help determine the outcome of the intervention. These may include direct nutrition outcomes (improved nutritional status) but may also include the following

* Clinical and health status outcomes (laboratory values, weight, risk factor profile changes, signs and symptoms)
* Patient/client-centred outcomes (quality of life, satisfaction, self-management, functional ability)

**Box 2a: Additional actions to be completed by named healthcare professional – delete if not applicable**

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| --- |
| **GP/Consultant/CNS/Other/AHP Actions** |
| E.g biochemistry monitoring / psych referral / vit D correction |

**Box 3: Prescription Request - delete if not applicable**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*\*\*\*\*NUTRITION PRESCRIPTION REQUEST\*\*\*\*\*** | | | | | | | | | |
| Name and Manufacturer | Flavour | Volume (ml/kg)  per serve | Quantity  /serve  per day | Total volume per 28days | Volume per serve | No of packs required for 28days | Duration  (weeks) | Prescription Type | ‘Patient information’ for prescription |
| Altraplen Protein | Vanilla | 200ml | 2 | 11200 | 800 | 14.0 | 4 | Acute | Mid morning and mid afternoon |
| Phlexy Vits (SHS) | N/A | 1 | 5 | 140 | 180 | 0.8 | 12 | Repeat | 5 tablets per day |
| Aymes Shake (Aymes) | Banana | 57kg | 2 | 3192 | 399 | 8.0 | 4 | Acute | Mix with 200ml full fat milk |
| Calogen  (Nutricia) | Neutral | 30ml | 3 | 2520 | 250 | 10.1 | 4 | Acute | Mix into milky drinks |
| Alfamino (Nestle) | N/A | 32.2 | 5 | 4508 | 400 | 11.3 | 12 | Repeat | 7 x 4.6g scoop with 210ml water per feed |

**Please note information on ‘Unit volume’ and ‘Total volume *for 28 days*’ and ‘number of packs required for 28days’** **has been included to ensure the correct volume of supplement is prescribed to the patient**

**Volume per serve=** volume per bottle/sachet etc or suggested volume to take per serve e.g. 30ml Calogen, 200ml Fortisip

**Unit** = ml/g/tablet etc (do not enter the unit ‘g’ or ‘ml’ in the ‘volume per serve’ column as the excel calculation will not work

**Total volume for 28 days =** total volume required for 28 days e.g Aymes Shake 57g sachet x 2 per day = 57 x 2 x 28 = 3192g

e.g Fortisip 200ml bottle x 2 per day = 200 x 2 x 28 = 11,200ml. An excel formula has been inserted to automatically calculate the volume required for 28 days – please ensure correct information is entered into ‘volume per serve’ and ‘quantity per day’.

**NB: 28 days will provide a one month prescription** to the patient. If the prescription request is for less than one month please calculate and insert information manually. If the prescription request is for more than 28 days – the patient will receive an initial one month/28day prescription (week 1-4) – the prescription will then be re-issued for a further 4 weeks (week 5-8). The GP will be informed the prescription should be re-issued via the **‘Duration’** of prescription column.

**Quantity/serves per day** = no of supplements/servings of formula to take per day

***\* No of packs required to achieve prescription volume (ONS only)****: many GP electronic systems will only inform the prescribing clinician of the total volume a ‘pack’ of supplements contain (e.g Fortisip 800ml) and will not provide information on the volume*

*of a single unit contains (e.g Fortisip 200ml bottle) – for this reason the number of ‘packs’ required to achieve the total volume of prescribed supplement for 28 days is helpful and aims to ensure the patient receives the correct quantity of supplement prescribed*

**e.g.** **\*** Aymes Shake: 57g per sachet; 7 x 57g sachets per pack = total of 399g. Therefore, 8 x 399g will provide 3192g

**\*** Fortisip: 200ml per bottle; 4 x 200ml per pack = total of 800ml. Therefore, 14 x 800ml will provide 11,200ml.

***For information regarding standard pack sizes please see Appendix 1 attached.***

**Prescription Type**

**Please state both duration of prescription and prescription type**

**Duration of prescription –** will inform GP if the prescription request is to be re-issued e.g. 8 week prescription will be issued twice.

**Repeat prescription:** a prescription that is needed regularly and can be reissued without the patient having to see their doctor. **Acute prescription:** Short term prescription e.g. 4-8 weeks. This will promote the clinician to provide a patient review prior to issuing another prescription. This also aims to ensure prescriptions do not continue without monitoring and review.

**Specialist Information**

Patient message on prescription – this message will appear on the medication when issued to the patient e.g. Complete supplement after main meals. Take X medication with/before food.

**Box 3a: ‘Pop up’/Screen message – delete if not required**

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| --- |
| **‘Pop Up’/Screen message for prescription** |
|  |

**‘Pop-up/Screen message’ - This message will ‘pop up’ on the screen before the clinician issues the supplement prescription.**

For all prescriptions, specific goals of ONS intervention and a date to discontinue/review the prescription should be provided. This will support the GP in reviewing the prescription should the patient not attend dietetic follow up appointments. Please ensure

**N.B:** ‘pop up’ message is inserted when the plan is for the patient to be followed up by the dietitian. (Box 6). Otherwise, this information may be provided to the GP in box 6.

**Box 4: ABCS criteria – mandatory if oral nutritional supplements are requested**

**Delete box for adults/paediatrics as appropriate.**

|  |  |
| --- | --- |
| **Standard ACBS Indicator for Oral Nutritional Supplements (ONS) (BNF, 2015)** | |
| Bowel Fistula  Continuous Ambulatory Peritoneal Dialysis  Disease- related Malnutrition  Dysphagia  Following Total Gastrectomy  Growth Failure | Haemodialysis  Inflammatory Bowel Disease  Intractable Malabsorption  Pre-op preparation for undernourished patients  Short Bowel Syndrome |
| **Specific ACBs Indicator for Nepro:** Nutritional supplement in patients with chronic renal failure who are on haemodialysis or CAPD, or with cirrhosis, or other conditions requiring a high energy, low fluid, low electrolyte diet.  **\*\*\*\*\*NOT MANDATORY TO INCLUDE SPECIFIC INDICATOR\*\*\*\*DELETE ROW IF NOT REQUIRED\*\*\*\*** | |

|  |  |
| --- | --- |
| **Standard Paediatric ACBS Indicator for Oral Nutritional Supplements/Formula (ONS) (BNF, 2015)** | |
| Bowel Fistula  Continuous Ambulatory Peritoneal Dialysis  Disease- related Malnutrition  Dysphagia  Following Total Gastrectomy  Growth Failure | Haemodialysis  Inflammatory Bowel Disease  Intractable Malabsorption  Pre-op preparation for undernourished patients  Short Bowel Syndrome  Food allergy/intolerance including cow’s milk protein allergy |
| **Specific ACBs Indicator for Neocate Advance:** Proven whole protein intolerance, short bowel syndrome, intractable malabsorption, or other gastro-intestinal disorders where an elemental diet is indicated  **\*\*\*\*\*NOT MANDATORY TO INCLUDE SPECIFIC INDICATOR\*\*\*\*DELETE ROW IF NOT REQUIRED\*\*\*\*** | |

The Advisory Committee on Borderline Substances (ACBS) is responsible for advising on the prescribing of foodstuffs and toiletries. The ACBS have defined the above indicators for ONS and formula feeds to be prescribed; the individual patient should meet one or more of these indicators in order to meet the ACBS criteria for prescription. Food based strategies and over the counter supplements should be considered if the patient does not meet the ACBS criteria for ONS.

**Specific ACBs Indicator:**

Standard indicators for ONS prescription may be selected, it is not mandatory to include a specific ONS indicator. Information regarding the patient’s nutritional +/- medical diagnosis is included above.

**Appendix 2 of the British National Formulary provides information on the standard ACBs indicators for ONS prescription; specific ACBs indications are also listed for certain supplements – see example above.**

**Box 5: Additional information – delete if not required**

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| --- |
| **Summary of consultation (may include patient agreed goals)** |
| Include details of consultation and reason for review. Include rationale for supplements particularly if BMI >18.5. Detail specific side effects of treatment which necessitate the dietary intervention.  N.B The patient may also receive a copy of the letter - include information on ‘Patient Agreed Goals’ should you wish to communicate this information to the patient and clinician via the letter e.g. re-iterate verbal/written advice provided during consultation. |

**Box 6: Resources/ Education/ Advice – free text - delete if not required**

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| --- |
| **Resources/Education/Advice Provided** |
| Example: Lipid lowering  Patient seen for the second appointment out of three for lipid lowering advice…  Advice was provided on food labelling and the following points were discussed ….  The following information was provided:  Include hyperlinks if applicable: link to eg BDA food fact sheet  List diet sheets provided e.g: Small appetite leaflet provided |

**Box 7: Follow Up Arrangements**

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| **Follow Up Arrangements/** |
| \*\*DELETE AS APPLICABLE\*\* EXAMPLE PHRASES:  **GP PLEASE REVIEW.** Please review the ongoing need for ONS by (DATE). Please discontinue ONS if diet therapy goals above have been achieved and arrange to repeat nutritional screening in 1 month. If goals have not been achieved please contact the dietitian (details below) or refer patient to the (insert name e.g. LAMP/Paediatric ) community dietetic team. Please insert this information as a **‘pop up’** message on the patients ONS prescription.  OR  The patient will be seen in the community/acute setting by (name) (dietitian) on (date) Contact number:  OR  A further dietetic referral has been made to the (name of team) dietitians. They will arrange further follow up. Contact details: |

**If no follow up is arranged;**

Inform the clinician no dietetic follow up has been arranged. As per example above, insert appropriate information to enable the GP to monitor and review the patient’s progress post dietetic discharge. Provide information and advice on who to contact should concerns arise; this may include information on referring the patient back to the service. Please see completed example avove.

**If dietetic follow up is arranged;**

Ensure all information and contact details are included for example;

The patient will be referred to the LAMP Community Dietetic Team (Tel: 02030495422) for continued dietetic support.

Even if follow up is ongoing with named team ensure that this is still documented.

**Box 8: Anthropometry (Mandatory box if requesting ONS) – delete if not required**

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| --- | --- | --- | --- |
| **Dietetic Supporting Information** | | | |
| **Anthropometry** | | | |
| Weight (kg) : | Height (m) : | | BMI (kgm²): |
| Weight History: | | | |
| Weight Change e.g % weight loss or gain over specific time period: | | Malnutrition Risk Score e.g.MUST Score: | |
| Other Anthropometry: e.g hand grip strength/ waist circumference/ head circumference | | | |

For paediatric patients : Document centiles in brackets next to these e.g. Weight: 24kg (2nd centile)

Please see Appendix 3 for Bariatric anthropometric measurements.

**Box 9: Tube fed patients – delete if not required**

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| **Enteral feeding tube** | |
| **Type/ size** | Vygon 12Fr Balloon Gastrotomy |
| **Date of Placement/ Removal Date** \*delete as applicable | Placed 25.8.15 |
| **Enteral feeding regimen** | 1.5L Nutrison Energy Multifibre @ 125mls/hr provides 2295kcals, 90gProtein |

Please do not hesitate to contact me should you require any further information.

Yours sincerely

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