**Paediatric Dietetic Service for food allergy**

**This referral form is for food allergies only. For all other dietetic referrals please use the ‘Paediatric Dietetic Outpatient Referral Guide’ via RMS**

**We cannot accept incomplete referrals *Our waiting times can be long. Please maintain contact with the patient and continue to monitor until you receive correspondance that Dietetic contact has been made.***

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| --- | --- | --- | --- | --- | --- |
| **Does this child have a confirmed IgE or Non IgE food allergy?** | **No** |  | **Yes** |  | **Date of diagnosis:** |
| **Does this child have a suspected IgE or Non IgE. Please refer to the** iMAP allergy presentation algorithm to assist with diagnosis: <https://gpifn.files.wordpress.com/2019/10/imap-presentation-algorithm-1.pdf> | **No** |  | **Yes** |  | **If IgE allergy suspected please also refer to allergy clinic at RCHT** |

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | NHS No |  |
| Forename |  | D.O.B |  |
| Address | | Consent |  |
|  | | Gender |  |
| Telephone |  |
| Email |  |
| Post code |  | Name or parent/ carer |  |

|  |  |
| --- | --- |
| Relevant social history |  |
| Safeguarding considerations |  |
| Other services involved |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Has this child started weaning? | | | | | | Yes/ No | | Have any other allergies been identified? | | | | | | YES/NO if yes please provide details: | | | | | | | |
| Is this referral for an infant under 12 months who was born preterm (<37 weeks gestation) | | | | | | | | | | | | | YES/NO | | | | | | | | |
| For infants (please tick) | | | Breastfed | |  | Non-prescription formula | | | |  | Specialist prescribed formula | | | |  | Name of formula: | | | | | |
| If specialist formula has been prescribed is patient receiving age appropriate product (move to stage 2 for 6 months plus) | | | | | | | | | | | | | | | | | | YES/NO | | | |
| Weight (date) | |  | | | | | Centile | |  | | | Height (date) | | | |  | Centile | |  | | |
| Has faltering growth been identified? | YES/NO | | If yes please detail growth history and ensure Health Visitor has been informed: | | | | | | | | | | | | | | | | | | |
| If non IgE, has a one off milk challenge been performed? Please refer to the iMAP milk challenge protocol: <https://www.allergyuk.org/assets/000/001/298/Home_Reintroduction_Protocol_to_Confirm_or_Exclude_Diagnosis_original.pdf?1502805714> | | | | | | | | | | | | | | | | | | | | YES/NO | |
| Relevant past medical history/ additional information | | | |  | | | | | | | | | | | | | | | | |  |