**Department of Nutrition & Dietetics**

**Pharmacy request for dietetic assessment: Coeliac disease**

NB: If patient has any **red flags** (unintentional weight loss, sudden change in bowel symptoms, PR bleeding, new onset anaemia etc, please refer to the GP in the first instance)

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| Patient name: |  |
| CHI: |  |
| GP Practice: |  |
| Summary of reason for referral (e.g. not complying with GF diet/ More information on GF diet required etc): |  |
| Has patient consented to referral: | Yes/No (delete as appropriate) |
| Anthropometrics (if known): | Weight:.................... Height:............................BMI:........................... |
| Has patient previously seen a dietitian? | Yes/No/Unsure (delete as appropriate) |
| Most recent coeliac serology (TTG result) (if known) | Date:......................Result:..................... |
| Any other relevant information: |  |
| Referrer (name/contact details): |  |
| Date of referral: |  |

Please email completed referral form to: dg.dietetics@nhs.scot OR post to: Gastroenterology Dietitians, Mountainhall Treatment Centre, Bankend Road, Dumfries, DG1 4AP

Telephone number: 01387 241 568