FAX MESSAGE

2/191 Melbourne St
North Adelaide
South Australia 5006

Ph: (08) 8227 1000
Fax: (08) 8227 1200

admin@npagroup.com.au
www.npagroup.com.au

Nutrition Professionals Australia
solutions for a healthy life

To : Nutrition Professionals Australia

From:

Nursing Home Name:

Nursing Home Address:

Nursing Home Fax number:

Nursing Home Phone number: **Number of Pages:**

Date: **Sender:**

Subject: **Authorisation for Dietitian Review of Resident(s)**

Nutrition Professionals Australia (NPA) has been requested to review the following resident(s):

....

NPA will provide a suitably qualified Accredited Practising Dietitian to review your resident(s). Best practice and evidence based guidelines will be used when making recommendations for care. The dietitian will enter documentation into the clinical record and will provide clear guidelines and instructions if intervention is required. All of our dietitians have a $10m professional indemnity insurance cover and a current police check.

NPA's standard fees are as follows:

$150 per hour. Minimum of 1 hour.
Call out fee of $50 – waived if more than one resident is seen.

Note: All prices exclusive of GST. A Tax Invoice will be sent separately.
Any review visits will be negotiated as required and as clinically indicated.

Information needed

To ensure the most efficient service, the following information (where relevant) should be readily available to the dietitian on arrival:

- Medical history
- Reason for referral/ key issues
- Clinical notes- or a login to the electronic system
- Dietary requirements forms
- Weight charts
- Food intake charts
- Drug charts

Authorisation:

Please complete the details below including your signature and the details regarding the resident on the attached page.
Please copy and complete additional forms if multiple residents need to be seen.
Please then return all pages to NPA by return fax 08 8227 1200.

Authorised by:

Name (please print): .... Signature: ....

Position: .... (Director of Care or CN or RN)

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RESIDENT DETAILS:

Resident Name: **DOB:**

Unit / Room No:

Visit time: (Usual visit time will be within one week of referral. Please indicate if the referral is more **urgent** than this time frame:

□ 1 to 2 days □ 3 to 4 days □ 1 week (standard)

Reason for referral:

□ Weight loss
Please specify: …………..kg in 1 month …..…....kg in 3 months ………….kg in 12 months

□ Diabetes (Type 1/Type 2) Insulin? Yes / No

□ Weight gain
Please specify: …………..kg in 1 month …..…....kg in 3 months ………….kg in 12 months

□ Modified texture diet: □ Soft □ Minced and moist □ Smooth puree

□ Thickened fluids:- □ Mildly Thick Level 150 □ Moderately Thick Level 400 □ Extremely Thick Level 900

□ Enteral feeding (PEG)

□ Allergy or intolerance
Please specify ………………………………………………………………..

□ Other ..……………………………………………………………………………….

Medical problems:

Current issues impacting on nutrition/ hydration:

Who is responsible for payment of account?

□ Facility □ DVA Gold Card* □ Resident

*Medical Practitioner referral required