#### Medically Prescribed Diets - Form 2025

This form is intended for children who have a diagnosed health condition and/or multiple food allergies that require a medically prescribed diet. The form should be completed by a Medical Practitioner and/or Registered Dietitian. For requests involving oral textured diets or blended diets for PEG feds, the referral must be completed by a Dietitian and/or a Speech and Language Therapist. **Where a food allergy is also present, collaboration between both professionals** **is** **essential to ensure the correct adapted menu is implemented.**

Please return this form completed and signed to Facility Support Services, Nutrition Team at SpecialDiet@northlan.gov.uk

**Personal Information -** (Please write in block capitals if handwritten).

|  |  |
| --- | --- |
| Childs Name: |  |
| Date of Birth: |  |
| Name of Parent / Guardian: |  |
| Tel No: |  |
| Home Address:  |  |
| **Email:**(*this is the main form of contact)* |  |
| Name of school, nursery or other catering unit: |  |
| If nursery, which days is your child in attendance: |  |

**Information Regarding the Medical Diet Required**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please select the relevant box for this adapted menu.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Food |  | Food  |  | Health Conditions |  |
|   | Allergy |  | Intolerance |  | (please select below) |   |

**Oral Textured Diets or Blended Diets for children that are being PEG fed.**

Please select the relevant box for this adapted menu.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Texture  |  | Blended Diet  |
|  | Modification  |  | (PEG Fed) |

**Please indicate the Texture level using the IDDSI framework, if applicable.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Enteral Feeding/Blended Diet

🡪 Volume required for school meals.

 \_\_\_\_\_\_\_\_\_\_\_ mls

🡪 Minimum protein intake for school meal \_\_\_\_\_\_ g

**Health Conditions**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Type 1 Diabetes  |  | Coeliac Disease |  | Type 1 Diabetes & Coeliac  |
|  | PKU |  | Cystic Fibrosis  |  | Other |

Any other type of health condition that is not listed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Other requests, if applicable.

Please select all relevant allergies only (from the 14 allergens)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Celery |  | Cereals  |  | Crustaceans |  | Egg |  | Fish |
|  |  |  | (gluten)\* |  |  |  |  |  |  |
|  | Lupin |  | Milk |  | Molluscs |  | Mustard |  | Nuts |
|  |  |  |  |  |  |  |  |  |  |
|  | Peanuts |  | Sesame |  | Soya |  | Sulphur and Sulphur Dioxide  |

\*Cereals containing gluten (wheat, barley, rye, oats)

Other types of allergies (out with the 14 allergens)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Chickpeas |  | Lentils  |  | Peas  |  | Beans  |

Please sated yes or no below

|  |
| --- |
| Baked milk **Yes/No** Soya flour **Yes/No** Pea protein **Yes/No**Baked egg **Yes/No** Soya lecithin **Yes/No** |

Any other type of food allergies that are not listed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What foods/drinks will the child or young person react to?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please confirm if the child or young person can have “***may contain*” *products*** *(yes or no)*

Medication required if appropriate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Professional Contact Info**

|  |  |
| --- | --- |
| Name & work address of Dietitian / Medical Practitioner requesting diet: |  |
| Contact number of Dietitian/Medical Practitioner:  |  |
| **Signature of Dietitian/Medical** **Practitioner:** |  |
| Please enclose: | **Any relevant diet sheets or NHS letter.**  |

Thank you.

Please return this form completed and signed to the Nutrition Team at SpecialDiet@northlan.gov.uk