Peninsula Health | Building a Healthy Community, in Partnership

DIETETICS – TRANSITION CARE PROGRAM

The Transition Care Program (TCP) dietitian provides dietetic service for patients admitted to the 12-week program, on a referral basis. TCP patients are currently seen in their home (TCP-H).

Refer via email to TCP Dietitian (refer to Dietitian Contact List) and infotch@phcn.vic.gov.au or TCP Reception phone (03) 9788 1803.

TCP-H: WHO TO REFER

- Enteral feeds (established PEG/ tube feeding requiring ongoing nutrition support & monitoring)
- Malnutrition or unexplained and significant weight loss (>3kg in one month). Malnutrition Screening Tool (MST) score ≥ 2
- Individuals discharged from an inpatient admission requiring oral nutrition support (ONS)
- Pressure ulcers (stage 2 or greater) or non-healing, chronic wounds
- Prolonged poor oral intake
- Individuals with significant co-morbidities impacting oral intake (e.g. undergoing cancer treatment, cognitive impairment, dysphagia)
- Education for chronic conditions (e.g. diabetes or post stroke) – lower priority and depending on anticipated length of TCP stay. Discuss with TCP Dietitian.

Note: Registration for home delivered supplements (e.g. via NCare) should be completed prior to discharge from the inpatient ward

Before referring to TCP, consider:

Has the nutrition diagnosis changed or resolved, e.g. does the patient still have increased nutrition requirements, has a pressure injury healed?

WHEN TO REFER TO AN OUTPATIENT/COMMUNITY SERVICE

- Where stable intake/ONS regime has been established, but long term monitoring is required
- Long term monitoring and education for chronic conditions (e.g. diabetes, renal disease)

Refer to service guides on Prompt for more information:

Community Health
http://prompt.phcn.vic.gov.au/Search/download.aspx?filename=17836107\17836641\53180835.pdf

Community Rehabilitation Program
http://prompt.phcn.vic.gov.au/Search/download.aspx?filename=17836107\17836641\51460325.pdf