DIETITIAN REFERRAL FORM

Date *(yyyy-mm-dd)*	**Fax this form to:** 877-452-5023

Patient Information

First Name	Last Name	Phone
Address	E-mail	Birthdate*(yyyy-mm-dd)*

Referring Physician/Professional Information

Referral Source	Phone	E-mail
Family Physician	Phone	E-mail

Referral Information Please check reason(s) for referral ***(required)***

Adult (18+ years) ***Please attach relevant labs and meds****

- □ Allergies/Intolerances *(specify)* _____
- □ Cancer
- □ Cardiovascular disease/hypertension*
- □ Celiac Disease
- □ Cholesterol
- □ Crohn's/Colitis Disease
- □ Diabetes* □ Type 1 □ Type 2 □ Prediabetes
- □ Disordered Eating *(specify)* _____
- □ GI disease/concern *(specify)* _____
- □ Malnutrition *(unintentional weight loss/poor appetite)*
- □ Pregnancy
  - □ Prenatal nutrition
  - □ Post-partum nutrition
  - □ Gestational Diabetes
  - □ Excessive weight gain
- □ Renal
- □ Senior
  - □ Dysphagia
- □ Thyroid Disorder
- □ Weight management (gain)
- □ Weight management (loss)
- □ Other *(specify)* _____

Pediatric (0-17 years) ***Please attach growth charts****

- □ Allergies/Intolerances *(specify)* _____
- □ Celiac Disease
- □ Delayed texture progression
- □ Enteral feeds
- □ GI concerns *(specify)* _____.
- □ Growth pattern concerns
- □ Growth faltering
- □ Weight ahead of length
- □ Iron deficiency
- □ Picky eating
- □ Other *(specify)* _____

Please attach relevant lab and medication data*

□ Labs attached

Examples: Triglycerides, Total Cholesterol, LDL-Cholesterol, HDL-Cholesterol, Hematology, Ferritin, HbA1C, Fasting Blood Glucose, Sodium, Potassium, Magnesium, Phosphate, B12, Thyroid marker, Liver markers

□ Medications attached

Other relevant medical history/important considerations *(eg. weight history, bariatric surgery, prematurity, unmanaged personality disorders):*

Booking Information – ***Please complete for consultation/care of this patient***

- □ Full Assessment as soon as possible
- □ 15minutes free consultation
- □ Full Assessment within _____ days
- □ Under 18 years of age - *name of parent/legal guardian* _____
- □ Other *(specify)* _____

Tracking – ***Office Use Only***

□ Redirected To: _____ Date: _____ □ Contacted client: 1st attempt: _____ 2nd attempt: _____ 3rd attempt: _____	□ Booked appointment: Date: _____ Time: _____ □ "Scheduled appointment" email sent □ Rescheduled appointment: Date: _____ Time: _____ □ "Rescheduled appointment" letter sent	□ Patient declined service □ Appointment cancelled □ Patient did not attend scheduled appointment □ "Patient not seen" letter sent