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Booking Tel: (604) 412-6200 or 1(855) 412-6200
Fax: (604) 412-6168 or 1(855) 412-6168

Outpatient Nutrition Counseling Referral Form

Please Fax to: 604-412-6168 or 1-855-412-6168

Site (Please circle): BH CGH DH ERH FCH LMH PAH RMH JPOC (SMH)

Is this referral urgent? Yes or No

If a nutrition counseling appointment comes up earlier at another site, do you wish to have your patient booked at the different site? Yes or No

Patient Information:

Last Name:______________________ First Name: __________________

□ Male □ Female DOB:______________________ (d/m/y)

PHN :__________________________

Address:____

Phone:____________________ (home) ___________________ (other)

Primary Language Spoken__________________ Interpreter required? □ YES □ NO

Height:__________ Weight:____________ BMI: __________

IMPORTANT

Please Attach Relevant Recent Lab Results i.e. Renal Indices, Lipid Profile, FBS, etc.

***Referral may be returned if not attached**

Physician Stamp Information:

Family Physician:	Specialist/Consulting:
Name:	Name:
Phone:	Phone:
Fax:	Fax:

Signature of Referring Health Care Provider:_____________________ Date:_______________

Primary Reason for Referral:

Comments:

Related Medical Issues:

□ Heart Disease	□ Dyslipidemia	□ Diabetes	□ Hypertension
□ Renal Disease	□ G.I. Concerns	□ Allergies	□ Depression
□ Weight Issues	□ Pregnancy	□ Eating Disorder	□ Other:______________

Medications/Supplements (Please list or attach):

Office Use Only