02.7550-50(05/10)D

River Valley Health
Dietitian Outpatient Referral

Name	
Address	
City	Postal Code
Medicare #	
Telephone (home)	(work)
DOB (dd/mm/yy)	
Physician	
Date of referral	

Please check (√) reason(s) for referral

- ☐ Anemia
- ☐ Cancer
- ☐ Cancer therapy symptom management
- ☐ Celiac disease
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Constipation
- ☐ Crohn's
- ☐ Diabetes ☐ New ☐ Review ☐ IGT ☐ IFG ☐ Gestational DM ☐ Hypoglycemia
- ☐ Diarrhea
- ☐ Diverticular disease
- ☐ Dumping syndrome
- ☐ Dysphagia
- ☐ Eating disorders
- ☐ Failure to thrive (FTT)
- ☐ Fibre modification
- ☐ Food allergies/intolerances
- ☐ Gallbladder
- ☐ Gastroesophageal reflux
- ☐ Gout
- ☐ Healthy eating
- ☐ Hepatic disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Iron deficiencies
- ☐ Irritable bowel syndrome
- ☐ Lactose intolerance
- ☐ Menopause
- ☐ Metabolic syndrome
- ☐ Neuromuscular disorders (e.g. ALS, MS, Parkinson's)
- ☐ Nutritional assessment
- ☐ Kidney stones
- ☐ Nutritional deficiencies
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Ostomy
- ☐ Pancreatitis
- ☐ Pediatric nutrition
- ☐ Prenatal nutrition
- ☐ Reactive hypoglycemia
- ☐ Renal disease
- ☐ Ulcers
- ☐ Vegetarianism
- ☐ Wound healing

☐ **Other diet** (be specific) _____

Additional Information/Lab Data _____

_____

_____

_____ _____ _____

Date Time Physician or Health Care Provider signature

Dietitian's Assessment Date received _____
Appointment _____

Assessment/Recommendations

Dietitian follow-up ☐ Yes ☐ No Follow-up date

_____ _____ _____

Date Time Dietitian signature