



Physician Referral
Ambulatory Care Dietitian
The Moncton Hospital
Tel: 857-5723 Fax: 857-5040

Unique #
Name
Address
City Postal Code
Medicare Expiry
Home # Work #
DOB (d/m/y)
Sex: Male Female
Name of Parent/Guardian

Date: Appointment Date:

Diagnosis/Reason for Referral:

For Eating Disorders: Psychology Referral Sent Psychiatry Referral Sent

If Diabetic or Glucose Intolerant, please refer to Diabetes Education Centre (DEC)

Other Medical History:

Medication:

Height: Weight: Exercise Limitation: Yes No

Additional Information (where applicable):

Blood Values All Tests Normal
Hgb HgA1C TC/HDL Risk Ratio
Glucose Pre-Albumin
BUN Creat. TSH
Potassium Other tests
Total Chol Total Triglycerides
LDL HDL

If pregnant, EDC (d/m/y): Weight Gain Expected

Diet Requested (check off one or more diets listed below)
Dyslipidemia - CHD risk: provide BP: Weight Reduction (provide height and weight above) High Energy Protein
High Potassium High Gluten Free Na
No Added Salt (biopsy blood test) K
High Fibre Low Fibre Healthy Prenatal/Postnatal High Folate
High Iron Purine Restricted Other:

Dyslipidemia and weight reduction referrals are usually seen in a class setting. Is there a reason why your client/patient should be individual? Please specify

Due to the number of clients missing appointments (or last minute appointment availabilities), we would like to call and remind your patient of their appointment (or offer them an earlier appt.).

If necessary, can a telephone message be left: NO YES Alternate phone #:

Physician's Name Signature

Referrals without adequate information will be returned

For Dietitian's Use Only: Date Referral Received: Referral No.:
1st available appt. offered: Date of 1st visit: