Physician Referral
Ambulatory Care Dietitian
Sackville Memorial Hospital
Tel.: 364-4115

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
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: ______/______
☐ High Potassium
☐ No Added Salt
☐ High Fibre
☐ Fibre Restricted
☐ High Iron

☐ Weight Reduction
(provide height and weight above)
☐ Gluten Free
(☐ biopsy ☐ blood test)
☐ Healthy Prenatal/Postnatal
☐ Purine Restricted
☐ Diet for Diabetes

☐ High Energy Protein
Renal: Protein ____________
Na ____________
K ____________
☐ High Folate
☐ Other: ____________

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:*** ____________

NOTE: This is a **CONTROLLED** document. Any document appearing in paper form is not controlled and should **ALWAYS** be checked against the electronic version prior to use. Printed on: 10/22/2013