RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

Physician Referral
Ambulatory Care Dietitian
Albert County Health and Wellness Centre
Tel.: 882-3100

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 ACHWC Diabetes Clinic
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
☐ 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:*** _____