RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

Clinical Nutrition
Outpatient Referral Form

Patient's Surname: _____ **Given Name(s):** _____

Complete Mailing Address:

_____

_____

Postal Code: _____

Birthdate: _____ _____ _____
Month Day Year

Medicare Number: _____

Language of choice: _____

Contact Person
(i.e. Patient/Guardian/Subsitute Decision Maker):

_____

Phone: _____ **(Evening)**

_____ **(Daytime)**

_____ **(Cell)**

Patient/Guardian/Subsitute Decision Maker

Signature _____

Diagnosis: _____

Reason for Referral: _____

Prescribed Medication: _____

Please Attach or Provide Pertinent Laboratory Value: _____

Other Pertinent Information: _____

Additional reports to be sent to: _____

❒ **Health Care Provider has discussed contact method with the patient/guardian/substitute decision maker. Permission is given to leave a telephone message as needed on telephone number:**_____

_____ _____ _____
HEALTH CARE PROVIDER **PHONE** **DATE**

Saint John Regional Hospital	**Charlotte County Hospital & Campobello Health Centre**	**Sussex Health Centre**	**Fundy Health Centre, Deer Island, Grand Manan**	**Community Health Centre**
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Saint John, N.B. E2L 4L2	St. Stephen, N.B. E3L 2L9	Sussex, N.B. E4E 2P7	Blacks Harbour, N.B. E5H 1K2	
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