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

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

_____

Phone: _____ (Evening)

_____ (Daytime)

_____ (Cell)

Patient/Guardian/Subsitute Decision Maker

Medicare Number: _____ Signature _____

Language of choice: _____

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**
Clinical Nutrition
P.O. Box 2100
Saint John, N.B. E2L 4L2
Phone: 506-648-6018
Fax: 506-649-2692

**Charlotte County Hospital & Campobello Health Centre**
Clinical Nutrition
4 Garden St.
St. Stephen, N.B. E3L 2L9
Phone: 506-465-4404
Fax: 506-465-4794

**Sussex Health Centre**
Clinical Nutrition
75 Leonard Dr.
Sussex, N.B. E4E 2P7
Phone: 506-432-3240
Fax: 506-432-3426

**Fundy Health Centre, Deer Island, Grand Manan**
Clinical Nutrition
34 Hospital Street
Blacks Harbour, N.B. E5H 1K2
Phone: 506-456-4221
Fax: 506-456-4222

**Community Health Centre**
116 Coburg Street
Saint John, N.B. E2L 3K1
Phone: 506-632-5537
Fax:506- 632-5539