



fraserhealth

# MATERNITY CLINICS DIETITIAN REFERRAL

## JIM PATTISON OUTPATIENT CARE AND SURGERY CENTRE



MSXX104851A

NEW: Aug. 2/11

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**JPOCSC 9750 140th Street Surrey, B.C. V3T 0G9 Phone: (604) 582-4558 ext 763993 Fax: (604) 582-3798**

**PLEASE COMPLETE IN FULL AND PRINT CLEARLY**

**Patient's Full Legal Name:** \_\_\_\_\_  
Last First Middle

**Other Name(s) (if applicable):** \_\_\_\_\_

**Personal Health Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(DD, MM, YYYY)

**Address:** \_\_\_\_\_  
Street City Province Postal Code

**Home Phone No.** \_\_\_\_\_  Okay to Call **Message Phone No.** \_\_\_\_\_

**Insurance Type**  MSP  WCB  Out-of-Province  Self-Pay Other: \_\_\_\_\_ RCMP or Armed Forces #: \_\_\_\_\_

**Interpreter Required:**  No  Yes **Language:** \_\_\_\_\_

**Age at referral:** \_\_\_\_\_ **Age at EDC:** \_\_\_\_\_ **Pre-registered at:** SMH  LMH  PAH  Other

Height: _____	<b>Circle which is the final EDC</b> <b>EDC by LMP:</b> _____ (DD/MM/YY) <b>EDC by U/S:</b> _____ (DD/MM/YY)
Pre gravid weight: _____	
Current weight: _____	

<b>G</b>	<b>T</b>	<b>P</b>	<b>SA</b>	<b>TA</b>	<b>L</b>	<b>Multiple gestation:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other
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**Reason for Referral:**

<input type="checkbox"/> Inadequate nutrient intake	<input type="checkbox"/> Poor eating habits
<input type="checkbox"/> Inadequate/ excessive weight gain	<input type="checkbox"/> Anemia
<input type="checkbox"/> Underweight/ overweight pre-pregnancy	<input type="checkbox"/> IUGR
<input type="checkbox"/> Nausea/ vomiting	<input type="checkbox"/> Vegetarianism
<input type="checkbox"/> Food allergy or intolerance	
<input type="checkbox"/> Other: _____	

**Additional Comments:** (e.g. if patient is not appropriate for group education phone patient directly etc.)

Printshop # 256781

### THE FOLLOWING RECORDS MUST BE RECEIVED TO PROCESS THIS REFERRAL

- Antenatal Record Part I and Part II (If started)
- Reports of all ultrasounds done in this pregnancy
- All available lab results; including serum integrated prenatal screen results, blood group and screen, CBC, prenatal screen, PAP smear results, FBS 2 hour OGTT (where indicated), A1C (within 3 months), electrolytes (if applicable, i.e. NVP), vaginal swabs
- All consultation reports and investigational records related to maternal diagnosis

**Family Physician (if different from referring source)**

Name: \_\_\_\_\_

MSP #: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient has no GP/NP

**Referring Health Care Provider:**

Name: \_\_\_\_\_

MSP #: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

GP  Specialist  NP  Hospitalist  ER  Other

**Referring Physician Signature:** \_\_\_\_\_