fraserhealth

DIETITIAN REFERRAL
Pediatric Outpatient - SMH

PATIENT INFORMATION

Name: _____ PHN# _____

Address: _____

Telephone: (Home) _____ (Work) _____

Birth Date (dd/mm/yyyy): _____ Gender: ☐ Male ☐ Female

Language Spoken: _____ Interpreter Required? ☐ Yes ☐ No

REASON FOR REFERRAL:

- ☐ Malnutrition / Failure to thrive or Poor growth
- ☐ Tube feed assessment
- ☐ NICU follow up / nutrition assessment
- ☐ Food allergies
- ☐ Celiac disease
- ☐ Vitamin or mineral deficiency (eg. iron deficiency)
- ☐ Picky or selective eater
- ☐ Hypertension
- ☐ Lipid disorder
- ☐ Constipation
- ☐ Vegan / vegetarian

Note: Referrals for **overweight management** will not be accepted and can be sent to Shapedown BC program or the Healthlink BC Eating and Activity Program.
Referrals for **eating disorders** can be sent to the Fraser South Eating Disorders Program or additional resources / services can be found at https://keltyeatingdisorders.ca/finding-help/programs/.

Additional Information (please include any relevant consults):

Medical History:

Medication / Supplements:

Oral / Enteral Diet:

PHYSICIAN INFORMATION

Referring Physician / Pediatrician: _____

Telephone: _____ Fax: _____

Family Physician: _____

Telephone: _____ Fax: _____

Physician's Signature: _____ Date: _____

*****Please include WHO growth chart with dates / measurements and relevant labs*****

Fax completed form to: 604-528-5449 Phone (booking office): (604) 585-5666, Local 772481