Referral for Outpatient Nutrition Counselling

FAX COMPLETED FORM TO (306) 766-2115

Regina Qu'Appelle HEALTH REGION

INDIVIDUALS WITH DIABETES, PRE-DIABETES OR GDM PLEASE MAKE REFERRAL TO:
REGINA MEDEC AT THE REGINA GENERAL HOSPITAL FAX (306) 766-4178

Patient Name		**DOB**		**GENDER**	☐ M / ☐ F
PARENT / GUARDIAN (REQUIRED IF < 18 YRS OLD)					
Address (with postal code)					
Primary Phone Number		**Secondary Phone Number**			
HSN Number					

TYPE OF NUTRITION COUNSELLING REQUESTED (PLEASE CHECK APPROPRIATE BOX)

PLEASE ATTACH A GROWTH CHART FOR THOSE CLIENTS UNDER 16 YEARS OF AGE

___ Obesity – ADULT **NOTE: INDIVIDUALS WITH DIABETES – REFER TO MEDEC –** ___ Cardiac ___ Dyslipidemia ___ Fatty Liver ___ Hypertension	___ Allergy ___ Celiac Disease ___ Crohn's / Colitis ___ Irritable Bowel Syndrome ___ Lactose Intolerance	___ Eating Disorder ___ Failure to Thrive ___ Underweight/Poor Nutrition	___ Pregnancy ___ Renal ☐ Other _____

OTHER MEDICAL CONDITIONS, SPECIAL TEACHING REQUIREMENTS (HEARING IMPAIRMENT, LANGUAGE OTHER THAN ENGLISH, ETC.)

MEDICATIONS

LABORATORY DATA				**ANTHROPOMETRICS**	
Triglycerides		**Albumin**		**HEIGHT (cm)**	
Total Cholesterol		**Hemoglobin**		**WEIGHT (kg)**	
HDL Cholesterol		**Proteinuria**		**BMI**	
LDL Cholesterol		**Other**			

ADDITIONAL COMMENTS

Physician or Nurse Practitioner Contact Information

Name

Mailing Address / Telephone Number

Date		**Physician or Nurse Practitioner Signature**	