Saskatchewan Health Authority

Referral for Outpatient Nutrition Counselling (Regina)

Patient Name:
Date of Birth: Sex:
Phone:
Address:
Postal Code:
HSN:
MRN:

INITIAL APPLICABLE BOXES

Parent/Guardian (Required if less than 18 years of age)

Secondary Phone Number: **Height (cm):** _____ **Weight (kg):** _____

Is the patient aware that they have been referred for Outpatient Nutrition Counselling? ☐ Yes ☐ No

Type of Nutrition Counselling Requested (Check applicable box[es])

Cardiac
- ☐ Dyslipidemia
- ☐ Hypertension
- ☐ Other: _____

Gastrointestinal
- ☐ Celiac Disease
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Other: _____

Hepatic
- ☐ Cirrhosis
- ☐ Fatty Liver

☐ Renal: _____

Eating Disorder
- ☐ Anorexia
- ☐ Bulimia
- ☐ Binge Eating Disorder

Food Allergies/ Intolerances
- ☐ Lactose Intolerance
- ☐ Other: _____

☐ Pregnancy _____

☐ Tube Feed _____

Weight Management
- ☐ Obesity
- ☐ Underweight/ Poor Nutrition

☐ Wounds

☐ Other: _____

_____

☐ Pediatric **(Attach growth chart for clients less than 16 years of age)**
- ☐ Allergy: _____
- ☐ Celiac Disease
- ☐ Failure to Thrive/ Underweight
- ☐ Iron Deficiency
- ☐ Other: _____

_____

**For General Nutrition and Picky Eating without Failure to Thrive, consider Health Promotion programs, including Raising a Healthy Happy Eater class, see: the SHA Health Promotion site https://www.rqhealth.ca/department/health-promotion/nutrition-and-healthy-eating **

For **adults with Diabetes (including Pre-Diabetes), **refer directly to: Chronic Disease Prevention and Management, Primary Health Care, Fax: 306-766-7222; Pediatric Diabetes refer directly to: Fax: 306-766-3461; Gestational Diabetes refer directly to 306-766-3329****

If more than one box checked above, what is the primary reason for the referral? _____

Additional Comments - Attach any relevant labs, test results or other information.

Physician or Nurse Practitioner Contact Information

Name (printed): _____ Mailing Address: _____

Phone: _____ (with postal code) _____

Date	**Practitioner Signature**

FAX COMPLETED FORM TO 306-766-0912