



NUTRITIONAL COUNSELLING CLINIC REFERRAL

Fax this completed form to the appropriate fax number (below) and the patient will be contacted directly

☐ NORTH SHORE
FAX 604-297-9681
Tel 604-984-5752

☐ RICHMOND
FAX 604-244-8599
Tel 604-233-5610

☐ ST. PAUL'S
FAX 604-806-8680
Tel 604-806-8486; press 3

☐ UBC HOSPITAL
FAX 604-822-7903
Tel 604-822-7192

PLEASE PRINT CLEARLY

PERSONAL HEALTH NUMBER:		DOB: YYYY/MM/DD 	NAME / ADDRESS OF REFERRING PHYSICIAN AND MSP PRACTITIONER # (or office stamp)
SURNAME OF PATIENT, FIRST NAME AND MIDDLE INITIAL			
MOST RELIABLE TELEPHONE #'S (INCLUDE AREA CODE): EMAIL:		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE PREGNANT: <input type="checkbox"/> YES <input type="checkbox"/> NO	
ADDRESS	CITY/TOWN	POSTAL CODE	COPY RESULTS TO:

☐ TRANSLATION SERVICES REQUIRED: (PLEASE INDICATE LANGUAGE) _____
(24 HOUR ADVANCED NOTICE REQUIRED)

PERTINENT HISTORY

REASON FOR REFERRAL / BRIEF HISTORY:

PLEASE PROVIDE A LIST OF CURRENT MEDICATIONS _____

PATIENT HEIGHT _____ PATIENT WEIGHT _____

ARE THERE ANY PRECAUTIONS OR SAFETY MEASURES THAT SHOULD BE CONSIDERED IN MEETING WITH THIS PATIENT? _____

**** FOR ALL REFERRALS ****

PLEASE ATTACH ALL RECENT BLOOD /LABORATORY /PERTINENT RESULTS/ PERTINENT CONSULT LETTERS

PLEASE NOTE:

ALL REFERRAL INFORMATION MUST BE COMPLETED IN FULL. INCOMPLETE REFERRALS WILL BE RETURNED

A FEE MAY BE CHARGED TO PATIENTS WHO FAIL TO PROVIDE AT LEAST 24 HOURS NOTICE OF CANCELLATION FOR A SCHEDULED APPOINTMENT