

**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 604-822-7255

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):	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE PREGNANT: <input type="checkbox"/> YES <input type="checkbox"/> NO	
EMAIL:		
ADDRESS	CITY/TOWN	POSTAL CODE
COPY RESULTS TO:		

TRANSLATION SERVICES REQUIRED: (PLEASE INDICATE LANGUAGE) \_\_\_\_\_  
 (24 HOUR ADVANCED NOTICE REQUIRED)

**P E R T I N E N T   H I S T O R Y**

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