Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Providence HEALTH CARE
How you want to be treated.

NUTRITIONAL COUNSELLING CLINIC REFERRAL

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

☐ NORTH SHORE	☐ RICHMOND	☐ ST. PAUL'S	☐ UBC HOSPITAL
FAX 604-297-9681	FAX 604-244-8599	FAX 604-806-8680	FAX 604-822-7903
Tel 604-984-5752	Tel 604-233-5610	Tel 604-806-8486; press 3	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): EMAIL:	☐ MALE ☐ FEMALE PREGNANT: ☐ YES ☐ 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