Vancouver Coastal Health

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 604-822-7192 |

PLEASE PRINT CLEARLY

| PERSONAL HEALTH NUMBER: | DOB: YYYY/MM/DD<br>\| \| | 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):<br><br>EMAIL: | ☐ MALE ☐ FEMALE<br>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