

Pediatric Nutrition Counselling Referral (Calgary Zone)

For clients with the following concerns, contact the corresponding program/service below:

- **General Infant Nutrition & Feeding** - Health Link @ 811
- **0 - 12 Months General Infant Nutrition & Feeding** - Feeding Your Baby group education. Self referral @ www.birthandbabies.com or 403.955.1450
- **1 - 5 Years Toddler Nutrition & Feeding Challenges** - Picky Eating group education. Self referral @ www.birthandbabies.com or 403.955.1450
- **Healthy Eating, Active Living, and Behaviour Change** - MEND = Mind, Exercise, Do It! Community based health lifestyle programs offered for children ages 2 - 13 years and their families. No referral required. www.albertahealthservices.ca/MEND.asp
- **Weight Management - Pediatric Services** - for children 2 - 17 years of age and BMI above the 85th percentile. *Outpatient Dietitian Counselling or Specialty Multidisciplinary Care Team Approach.* Services require referral from MD/NP. Access referral form @ www.albertahealthservices.ca/frm-18328.pdf

For all other referrals, complete the form and fax completed referral to Nutrition Services:

Urban Calgary Zone - 403.476.9621

Rural Calgary Zone - 403.476.9621

Patient will be contacted directly by Nutrition Services to book an appointment.

Patient Information

Date (yyyy-Mon-dd)	First Name	Last Name	
Date of Birth (yyyy-Mon-dd)	Personal Health Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Weight (kg)	Height/Length (cm)	Weight-for-length Percentile (birth - 24 months)	
BMI	BMI-for-age-Percentile (2 - 17 years)	<u>Attach Child's Growth Chart with this form</u>	
Medications		Vitamins	
Parent/Guardian First Name	Parent/Guardian Last Name	Contact Number	Alternate Number
Address		City/Town	Postal Code
Medical History/Pertinent Health Issues (If space below is insufficient, attach additional page)			
Limitations (physical/learning / language)			

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Patient First Name		Patient Last Name		Personal Health Number	
Primary Reason(s) For Referral					
Weight Measures Low:					
<input type="checkbox"/> Downward shift in growth pattern (<i>e.g. sharp decline, movement across percentiles nearing the 3rd percentile or growth line is flat</i>)					
<input type="checkbox"/> Below 3rd percentile weight - for - length (<i>birth - 24 months</i>)					
<input type="checkbox"/> Below 3rd percentile BMI - for - age (<i>2 - 17 years</i>)					
Weight is Ahead of Height/Length:					
<input type="checkbox"/> Upward shift in growth pattern (<i>e.g sharp incline or movement across percentiles or nearing 85th percentile BMI for age/weight for length on the WHO Set 2 Growth Chart. On CPEG Growth Chart nearing the 90th percentile weight for length.</i>)					
<input type="checkbox"/> Above 85th percentile weight for length on WHO Set 2 Growth Chart or 90th percentile on CPEG Growth Chart (<i>birth - 24 months</i>).					
<input type="checkbox"/> Food allergy(ies) or intolerance impacting diet adequacy					
<input type="checkbox"/> Iron Deficiency Anemia					
<input type="checkbox"/> Inappropriate diet for age (<i>e.g delayed texture progression</i>)					
<input type="checkbox"/> Feeding difficulties/caregiver education					
<input type="checkbox"/> Restricted diet resulting in nutrient deficiencies (<i>e.g vegan, picky eating</i>)					
<input type="checkbox"/> Other (<i>specify</i>) _____					
Comments					
Family Physician/Pediatrician					
First Name		Last Name		Signature	
Phone Number		Fax Number			
Referring Practitioner (please include professional designation)					
First Name		Last Name		Signature	
Phone Number		Fax Number			