Alberta Health Services

Nutrition Services Central Zone
Outpatient Dietitian Consult

Last Name	
First Name	
PHN#	Birthdate *(yyyy-Mon-dd)*

Date *(yyyy-Mon-dd)*	Fax to Nutrition Services **(403) 309-2872**

Patient Information

Address	Phone

Referring Physician/Health Professional Information

Referral Source	Phone	Fax
Family Physician	Phone	Fax

Referral Information ***Please attach relevant lab and medication data.*** Please check reason(s) for referral ***(required)***

Adult

- ☐ Cancer
- ☐ Cardiovascular disease/hypertension*
- ☐ Celiac Disease
- ☐ Diabetes* ☐ Type 1 ☐ Type 2
- ☐ Disordered Eating *(specify)* ______
- ☐ GI disease/concern *(specify)* ______
- ☐ Malnutrition *(unintentional weight loss and poor appetite)*
- ☐ Pregnancy
  - ☐ Excessive weight gain ☐ Other ______
- ☐ Renal
- ☐ Weight management* *(overweight, obesity)*
- ☐ Other *(specify)* ______

For gestational diabetes care or for group education regarding cardiovascular disease/hypertension, diabetes, or weight management, complete the **Alberta Healthy Living Program Referral form and fax to: 1-877-314-6993*

Pediatric (0-17 years) ***Please attach growth charts***

- ☐ Allergies/intolerances *(specify)* ______
- ☐ Celiac Disease
- ☐ Delayed texture progression
- ☐ Enteral feeds
- ☐ GI concerns *(specify)* ______
- ☐ Growth pattern concerns◊
  - ☐ Growth faltering
  - ☐ Weight ahead of length
- ☐ Iron deficiency
- ☐ Limited intake *(specify)* ______
- ☐ Picky eating
- ☐ Other *(specify)* ______

For diabetes pediatric care, complete the ***Alberta Healthy Living Program Referral*** form and fax to 1-877-314-6993

◊For 2-17 years and BMI over the 85th percentile, complete the ***Pediatric Weight Management Referral*** form and fax to: 1-866-979-3553

Other relevant medical history/important considerations *(eg. Autism, bariatric surgery, prematurity, unmanaged personality disorders, weight history):*

Booking Information. ***Please complete for any factors that may affect consultation/care of this patient***

- ☐ Language ______ ☐ Interpreter Required
- ☐ Hearing and/or Visual Impairment
- ☐ Resides in Group Home - *provide caregiver contact* ______
- ☐ Under 18 years of age - *name of parent/legal guardian* ______
- ☐ Other *(specify)* ______

Tracking – *Office Use Only*

☐ Redirected To: ______ Date: ______ ☐ "Redirect" letter sent ☐ "Referral acknowledgement" letter sent ☐ Contacted client: 1st attempt: ______ 2nd attempt: ______ 3rd attempt: ______	☐ Booked appointment: Date: ______ Time: ______ Location: ______ ☐ "Scheduled appointment" letter sent ☐ Rescheduled appointment: Date: ______ Time: ______ Location: ______ ☐ "Rescheduled appointment" letter sent	☐ Patient declined service ☐ Appointment cancelled ☐ Patient did not attend scheduled appointment ☐ "Patient not seen" letter sent