



PEDIATRIC DIETITIAN REFERRAL (CENTRAL ISLAND)

PLEASE FAX REFERRAL TO

- NSS Community Pediatric Dietitian Referral (250) 755-6260
- Pediatric Ambulatory Care Outpatient Dietitian (250) 739-5855

Patient Name: _____	PHN #: _____
Parent/Guardian Name: _____	
Date of Birth: _____	
Address: _____	
MRP/Pediatrician: _____	
GP: _____	
Home #: _____	Work #: _____
Cell #: _____	Text: <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address: _____	

<p>Outpatient Dietitian</p> <ul style="list-style-type: none"> <input type="checkbox"/> Disordered eating <input type="checkbox"/> Diabetes/endocrinology <input type="checkbox"/> Sensory issues with eating <input type="checkbox"/> Complex GI concerns <input type="checkbox"/> Vitamin/mineral concerns with growth failure <input type="checkbox"/> Multifactorial failure to thrive 	<p>Nursing Support Dietitian</p> <p><i>For clients with developmental disabilities and require a home visit</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Home tube feeds (<i>add feeding details below</i>) <input type="checkbox"/> Complex feeding and/or swallowing <input type="checkbox"/> Sensory issues with eating <input type="checkbox"/> Multifactorial failure to thrive
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Diagnosis: _____

Weight: _____ Height: _____

Please provide further details (medical history/diagnoses, tube feeding details, medications, and comments):

Please attach any relevant blood work and growth charts.

Booking Priority:

Urgent (within 1 week)
 ASAP (within 1 month)
 Routine (within 1-3 months)

Referral Source: _____ **Date:** _____

*Referrals for the following will **not** be accepted and can be redirected as appropriate.*

<p>HealthLink BC *811</p> <ul style="list-style-type: none"> • Picky eating • Vitamin/Mineral concern(s) • Vegetarian and Vegan diets • Allergies • Constipation <p><i>Health Care providers can request a referral from by calling *811</i></p>	<p>Central Island Healthy Lifestyles – Shapedown</p> <ul style="list-style-type: none"> • Healthy lifestyles • Obesity <p style="text-align: center;"><i>Please call (250) 755-7955 for more information</i></p>
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PAHC Clinic Use Only

Date of Appointment: _____	Expected time of arrival of pt: _____	<input type="checkbox"/> Virtual Appointment Booked
Date Clinic Notified: _____	Date Family Message Left: _____	<input type="checkbox"/> Telephone Appointment Booked
		<input type="checkbox"/> In-person Appointment Booked