



DIETITIAN REFERRAL FORM

Fax this form to: 1.855.933.2309 and the patient will be contacted within two business days. **NOT OHIP/HIBC/AHCIP COVERED** *If cost or insurance coverage is a concern, please choose 20-min free consultation from below.*

Patient Name	
Date of Birth	
Telephone / Mobile	
E-mail	
Referring Practitioner	

A) INDICATE THE NEED FOR NUTRITION SERVICES

	Healthy and sustainable weight loss Healthy weight gain		Fertility Pre/Post Pregnancy Nutrition
	Chronic Disease Management → Cholesterol → Blood pressure → Metabolic Syndrome → Coronary Heart Disease → Heart Attack → Stroke		Eating Disorders & Disordered Eating → Binge eating disorder → Emotional eating → Restrictive eating → Disordered eating → Bulimia / Anorexia Nervosa → ARFID
	Digestive Health → Food allergies/intolerances → IBS → IBD/UC/Crohn's Disease → Eosinophilic Esophagitis		Liver Health → Fatty Liver Disease → NAFLD → NASH
	Blood Sugar Management → Hypoglycemia → Prediabetes, impaired FBG, OGTT → Type 1 or Type II diabetes		Hormone Health → Thyroid Disorder → Peri/Post-menopause → PCOS (polycystic ovarian syndrome)
	Pediatric Nutrition, including Picky Eaters Program		Other:

B) PERTINENT INFORMATION/LABS

C) APPOINTMENT PREFERENCE

	Attached		20-minute free consultation
	Triglycerides, Total Cholesterol, LDL-Cholesterol, HDL-Cholesterol eGFR Hematology Fasting Blood Glucose HbA1c Sodium Potassium Optional: Ferritin, B12, Thyroid markers		Full Assessment as soon as possible
			Full Assessment within ____ days
			Full Assessment after date:

To print more referral forms, please visit <https://nutriprocan.ca/referral-form>