



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.

NUTRITION THERAPY CASE STUDIES: SIGN UP WITH YOUR CLINIC EMAIL:

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		Pediatric Nutrition, including Picky Eaters Program
	Chronic Disease Management → Cholesterol → Blood pressure → Metabolic Syndrome → Coronary Heart Disease → Heart Attack → Stroke		Women's Health → Fertility → Pre / Post Pregnancy Nutrition _____ → PCOS (polycystic ovarian syndrome) _____ → Peri / Menopause / HRT Support → Endometriosis → PMS _____
	Digestive Health → Food allergies/intolerances → IBS → IBD/UC/Crohn's Disease / Colitis → Eosinophilic Esophagitis		Liver Health → Fatty Liver Disease → NAFLD → NASH
	Blood Sugar Management → Hypoglycemia → Prediabetes, impaired FBG, OGTT → Type 1 or Type II diabetes		Healthy Eating Habits → Personalized Meal Planning → Mood & Food → Selective Eating _____
	Other:		

B) PERTINENT INFORMATION/LABS

C) APPOINTMENT PREFERENCE

	Attached		15-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/referrals>

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