Nutririon4u Consultancy

Physician Referral Form for Nutritional Consultation

Patient's Name:	Gender: M / F	Date of Birth:
Home Address:		
City:	Province:	Postal Code:
Home Phone:	Work Phone:	

Doctor's Name:	Phone Number:
Clinic Address:	
Reason for Referral:	
Diagnosis:	
Number of RD visits Required:	

Co-morbidities (Please check all that apply):	
☐ Allergies, Sensitivities	☐ Hypertension
☐ Autoimmune Disease, Arthritis, Lupus	☐ Nutrient Deficiencies, Failure to Thrive
☐ Osteoporosis	☐ Stroke, Alzheimer's, Dementia
☐ Cancer	☐ Pregnancy Complications
☐ Cardiovascular Disease	☐ Psychiatric Disorders, Anxiety
☐ Diabetes	☐ Pulmonary Disease
☐ Disordered Eating	☐ Renal Disease
☐ Dysphasia	☐ Substance Abuse, Alcoholism
☐ GI Disorder, specify:	☐ Obesity
☐ Hematological Disorder, Anemia	☐ Wound Care
☐ Hepatic Disorder	☐ Other:

Patient Information	
Age:	Height:
Current Weight (lbs or kg):	Blood Pressure:
Iron (Serum Hgb mg/dL):	Blood Sugar (Serum Glucose mmol/l):
Blood Lipids: (CHOL, HDL, LDL, TG):	
Other Lab Values:	

Physician's Signature:	Date:	
Physician's Phone #:		Fax #:

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