**[ ]  Belleville General T: 613-969-7400 x 2028 Fax: 613-961-2522**

[ ]  **Trenton Memorial T: 613-969-7400 x 2028 Fax: 613-961-5526**

[ ]  **PEC Memorial T: 613-476-1008 x 4525 Fax: 613-471-1647**

 Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Please Note:** Patients with Diabetes, IFG or IGT please use the **Quinte Health Diabetes Education Centre Referral form.**  |
| Patient’s Name: | Date of Birth: | Health Card Number: |
| Address: | Home Phone:Cell Phone: Business Phone: |
| Parents/Caregiver’s Names (if applicable): |
| Family Physician/Referring Practitioner: | Physician/Practitioner Phone:Physician/Practitioner Fax: |
| **Clinical Information and Medical History** |
| **[ ]  Adult**Ht: \_\_\_\_\_\_\_\_\_ Wt: \_\_\_\_\_\_\_\_\_ [ ]  Anemia[ ]  Celiac[ ]  CKD [ ]  Crohn’s[ ]  Colitis[ ]  Diverticulitis[ ]  Eating Disorder[ ]  Food Allergy/Intolerance[ ]  GERD[ ]  Hypercholesterolemia[ ]  Hypertension | BP: \_\_\_\_\_\_\_\_\_\_[ ]  Hypertriglyceridemia[ ]  IBS[ ]  Liver \_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Malnutrition[ ]  Osteoporosis[ ]  Overweight/Obese[ ]  Short Bowel[ ]  Unexplained Wt Loss[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]  Pediatrics**Ht/Length: \_\_\_\_\_\_\_\_\_ Wt: \_\_\_\_\_\_\_\_\_ [ ]  Eating Disorder[ ]  Failure to Thrive/Poor Growth[ ]  GI Problems (i.e. constipation)[ ]  Inadequate Intake[ ]  Anemia[ ]  Feeding Difficulties[ ]  Food Allergies/Intolerances[ ]  Recent Decrease in Weight[ ]  Excess Weight Gain[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**NOTE: Please send current growth charts.** |
| Significant Medical History: | Diet Prescription: |
| Pertinent Labs (or attach most recent labs):  |
| Medications (or attach current medications): |
| Physician Signature: Date: |
| **OFFICE USE ONLY**Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Appointment Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Attempted Contact:1. LM Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. LM Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3. Letter faxed to physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |