 **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |