Vancouver CoastalHealth
*Promoting wellness. Ensuring care.*

Gordon & Leslie Diamond
Health Care Centre
4th Floor, 2775 Laurel St,
Vancouver, BC V5Z 1M9.

# Adult Outpatient Dietitian Clinic

*Patient Label*

Referral Date: _____ **Please FAX Completed Form to: 604 875 4442.**

## Do you have access to the Vancouver PCN IPT resources? ☐Yes ☐No

If yes and meeting the referring criteria for the Vancouver PCN dietitians, please refer to there instead.

If no, please proceed with filling out this referral form and note that client must be living in Vancouver and Richmond area.

| **Client Information** | **Referring Physician /Practitioner Information** |
|---|---|
| Name: _____<br>Address: _____<br>City: _____ Postal Code: _____<br>Phone: _____<br>D.O.B. _____ Sex: ☐M ☐F<br>PHN: _____<br>Ht: _____ Wt: _____ | Name/Address<br>(or Office Stamp)<br><br>Phone: _____ Fax: _____<br>Copy Results To: |

## Primary Reason for Referral (Please check all that apply)

| | |
|---|---|
| ☐ Celiac Disease | ☐ Inflammatory Bowel Disease (Crohn's Disease, Ulcerative Colitis) |
| ☐ Dysphagia | ☐ Irritable Bowel Syndrome |
| ☐ Eosinophilic Esophagitis/Gastritis | ☐ Metabolic Syndrome |
| ☐ Failure to Thrive/Unintentional Weight Loss | ☐ Recurrent Bowel Obstructions |
| ☐ Food Allergies/Intolerances _____ (impacting adequacy of diet) | |
| ☐ GI Surgery _____ | ☐ Other _____ |
| ☐ Ileostomy | |

## Co-morbidities **must have 2 or more to be eligible for referral if no primary reason listed above**

| | |
|---|---|
| ☐ Anemia | ☐ Hypertension |
| ☐ Chronic Kidney Disease | ☐ Obesity |
| ☐ Diabetes | ☐ Osteoarthritis |
| ☐ Disordered Eating | ☐ Osteoporosis |
| ☐ Dyslipidemia/Hyperlipidemia | ☐ Restrictive Diet _____ |
| ☐ Gastroesophageal Reflux Disease | |
| ☐ Gout | ☐ Other _____ |

## Additional Risk Factors (Please check all that apply)

| | |
|---|---|
| ☐ Substance Abuse _____ | ☐ Decreased Mobility |
| ☐ Cognitive Impairment _____ | ☐ Mental Health Condition _____ |
| ☐ Lack of Social Support | |
| ☐ Limited Financial Resources | ☐ Other _____ |

**Interpreter required:** ☐Yes ☐No Language: _____

**PLEASE ATTACH ANY RELEVANT MEDICAL HISTORY, MEDICATIONS, BLOOD WORK OR OTHER TEST RESULTS**

Revised Nov 1, 2024