REGIONAL CHRONIC DISEASE EDUCATION TEAM and COMMUNITY DIETITIAN REFERRAL

- To allow us to provide the best and most timely care, please complete this form in as much detail as possible.
- Select Community/Site of Service Delivery from drop down list (for Accuro users)
  and/or **Chronic Disease Intake locations at www.southernhealth.ca**

Client Information: Male [ ] Female [ ]
Name: ______________________
Tel: (H)__________ (W) __________
Cell: ______________________
Mailing Address: ______________________
____
D.O.B. (m/d/y): ______________________
MHSC#: ______________________
PHIN#: ______________________
Weight: __________ Height: __________
Name of Guardian/Caregiver: __________
__________ Tel: __________

Referral Source:
Date of Referral: ______________________
Name: ______________________
Relationship to Client: ______________________
____
Primary Care Provider: ______________________
____
Clinic: ______________________
Address: ______________________
____
Tel: __________ Fax: __________

REASON FOR REFERRAL: ____
____
____

***Attach medical history and pertinent labs**
*** Complete box below if wanting insulin started or adjusted (signature required below to proceed)**

Name of Insulin	Route	Dosage	Time	Frequency	Certified Diabetes Educator (CDE) to adjust (Yes or No)

Prescriber Signature: ______________________ **Date:** ______________

MEDICATION AND DOSAGES: (list below or attach) ______________________________
____
____

Special Considerations:
[ ] Vision Impairment [ ] Hearing Impairment [ ] Language __________ Need Translation Services [ ] Yes [ ] No
[ ] Physical or Cognitive Limitations:______________________________________
[ ] Other:____

Signature of Person Referring: ______________________ **Date:** ______________

Regional Chronic Disease Education/Community Dietitian Office Use Only:
Date Referral Received: ______________________ Date Referral Booked: ______________________