Patient Label
Name:_____
HCN: _____
DOB: (dd/mm/yyyy) _____
Address: _____
Phone: _____
Family Dr. _____

Outpatient Medical Nutrition Therapy Referral Form

Patient referrals will be triaged based on reason for referral/ information provided on the referral form.

Preferred name and pronouns: _____

If minor, parent/guardian's name: _____

Alternate phone number: _____

Is an interpreter needed? ☐ Yes ☐ No If yes, please specify which language: _____

Are there any accessibility concerns? ☐ Yes ☐ No If yes, please specify: _____

Previous Dietitian (RD) referral: ☐ No ☐ Yes, please explain:_____

Is group education setting appropriate? ☐ Yes ☐ No

Reason for medical nutrition therapy:_____

_____

Relevant medical history: _____

_____

Relevant social history: _____

_____

Please include when possible: Ht _____cm Date:_____ Wt _____kg Date: _____ ☐ Growth chart for pediatric patient

If Applicable: BMI _____ Date: _____ Edmonton Obesity Staging System (EOSS) _____

Relevant Medications (that supports the referral): _____

_____

Relevant Lab data (Please include pertinent lab values to support referral and date): _____

_____

Consent to contact patient / delegate:
By confirming the information below, the referral source confirms that the patient gives their consent for NSH to contact them regarding this referral.

☐ Patient ☐ Delegate If delegate, specify relation to patient: _____

Consent to leave voicemail: Primary phone: ☐ Yes ☐ No Alt. phone: ☐ Yes ☐ No

Consent to mail letters to address: ☐ Yes ☐ No **Consent to e-mail letters**: ☐ Yes ☐ No

Referring Healthcare Provider (please print) _____

Patient Appointment Type Preference ☐ Telephone ☐ Zoom ☐ In-Person *Preference type will be given where possible but not guaranteed.*

Referring clinic name and address: Name: _____

Address: _____

Phone: _____**Fax:** _____**Date:** _____

Outpatient Clinical Nutrition Referral

Northern Zone:

Amherst Nutrition Clinic
Amherst
Fax: 902-667-4460

All Saints Springhill Hospital
Fax: 902-667-8812

Aberdeen Regional Hospital, New Glasgow
Fax: 902-752-3702

Colchester East Hants Health Centre, Truro
Fax: 1-844-903-4618

Fax all referrals to the above number for:
Truro **Tatamagouche**
Kennetcook **Bass River**
Indian Brook **Millbrook**
Elmsdale

South Cumberland Community Care Centre, Parrsboro
Fax: 902-667-8812

North Cumberland Memorial Hospital, Pugwash
Fax: 902-667-8812

Eastern Zone:

Eastern Memorial Hospital, Canso
Fax: 902-366-2227

Guysborough Memorial Hospital
Fax: 902-533-4066

St. Mary's Memorial Hospital, Sherbrooke
Fax: 902-522-2556

Inverness Consolidated Memorial Hospital
Fax: 902-258-3765.

Strait Richmond Hospital, Evanston
Fax: 902-625-3805

St. Martha's Regional Hospital, Antigonish
Fax: 902-867-4442

Cape Breton Regional Hospital Nutrition Clinic, Sydney
Fax: 902-567-3357

Glace Bay Nutrition Clinic
Fax: 902-849-7707

Northside Nutrition Clinic, North Sydney
Fax: 902-794-8885

New Waterford Nutrition Clinic
Fax: 902-862-8277

Western Zone: Provincial Contact Email: **WZNutritionBookings@nshealth.ca**

Yarmouth Regional Hospital
Fax: 902-742-3347

Digby General Hospital
Fax: 902-245-3005

Roseway Hospital, Shelburne Email: WZNutritionBookings@nshealth.ca

South Shore Regional Hospital, Bridgewater
Fax: 902-527-5250

Queen's General Hospital, Liverpool
Fax: 902-354-2018

Fisherman's Memorial Hospital, Lunenburg
Fax: 902-634-7334

Annapolis Community Health Centre
Fax: 902-532-2113

Soldiers' Memorial Hospital, Middleton
Fax: 902-825-5113

Western Kings Memorial Health Centre, Berwick
Fax: 902-538-0875

Eastern Kings Memorial Health Centre, Wolfville
Fax: 902-542-4619

Valley Regional Hospital, Kentville
Fax: 902-678-3727

Central Zone:

Medical Nutrition Therapy Centre
Phone Number: 902-473-6584
Fax Number: 902-473-3847

Preferred location by the patient *(Please check one)*
□ Victoria General, Dickson Building (VG)
□ Twin Oaks Memorial Hospital
□ Musquodoboit Valley Memorial Hospital
□ Dartmouth General Hospital
□ Eastern Shore Memorial Hospital
□ Central Zone IBD Clinic

Community Health and Wellness
Fax: 902-434-4022

Preferred location by the patient *(Please check one)*
□ North Preston □ East Preston

OFFICE USE ONLY:
Date received: _____

Appointment date: _____
Comments: _____
_____