



NORTH METRO HEALTH SERVICE

DIETITIAN REFERRAL FORM

PATIENT DETAILS

Date _____

Name _____

Address _____

Telephone (Home) _____ (Work) _____

Date of Birth _____

MEDICAL DETAILS

Reason for Referral:

Healthy Lifestyle Group (Overweight, Dyslipidaemia, or Hypertension)

Poorly Controlled Type 2 Diabetes

Underweight/Poor Nutrition

Gastrointestinal (Irritable Bowel, Coeliac, Crohn's, Diverticulitis etc.)

Child and Antenatal Nutrition

Other _____

Primary Dx: _____

PMHx: _____

Medications: _____

Lab Results: _____

REFERRAL NOTES

Referred By : _____ Signed _____

PLEASE SEND ALL REFERRALS TO:

Nutrition & Dietetics Department
Osborne Park Hospital
Osborne Place, Stirling 6021
Telephone: (08) 9346 8128
Facsimile: (08) 9346 8232