Cheryl Corry, Registered Dietitian Referral Form

Referral Date: _____ Referring Physician: _____

Physician Phone: _____ Physician Fax: _____

Patient's Name: _____DOB: _____Gender: ☐Male ☐Female

Please check (√)patient's preferred contact phone number:
☐Home: _____☐Mobile: _____☐Work:_____

Pertinent Medical History_____
_____

***PLEASE ATTACH RELEVANT BLOOD WORK**

Medications:	Dose:	Frequency:

Reason for referral: Please put a check (√) in appropriate box(es)

Diabetes:	**Cardiovascular:**	**Weight issues:**
☐Type 1 Diabetes	☐Hypertension	☐Underweight Pediatric (0-18 yrs.)
☐Type 2 Diabetes	☐Dyslipidemia	☐Overweight Pediatric (0-18 yrs.)
☐Gestational Diabetes	☐Other Cardiac	☐Underweight Adult/Senior
☐Impaired Glucose tolerance		☐Overweight Adult/Senior
☐Hypoglycemia		
Gastrointestinal:	**Systemic:**	**Healthy Eating:**
☐Irritable Bowel Syndrome	☐Eating Disorders	☐Perinatal Nutrition
☐Inflammatory Bowel Disease	☐Cancer	☐Pediatric Feeding Issues
☐Gas/Bloating	☐Anemia- Iron Deficiency	☐Adult Nutrition (19-64 yrs)
☐Constipation	☐Anemia- B12/folate Deficiency	☐Senior Nutrition (65 yrs and over)
☐Diarrhea	☐Food Allergies_____	☐Vegetarianism
☐Intolerance_____	☐Electrolyte Imbalance	☐Sport Nutrition
☐Sensitivity_____	☐Autoimmune Disease	☐Behavioural/Social Issues
☐Diverticular Disease	☐Thyroid Dysfunction	☐Food Affordability/Availability
☐Celiac Disease		
☐Dysphagia		
☐Pancreatitis		
Hepatic/Renal:	**Joint/Bone:**	**☐Other (Please Specify):**
☐Fatty Liver	☐Gout	
☐Liver Disease (other)_____	☐Arthritis	
☐Renal Problems/Disease	☐Osteoporosis	

Fax: 1-289-813-8825 Tel: 289-529-0339 cheryl.corry@nutritionpathway.com