island health

Cowichan District Hospital Outpatient Nutrition Services Referral

Note: Diabetes Education Program Requires Specific Referral Form

Patient Name	
DOB & Age	
BC Personal Health Number	
Address	
Name of Parent (if applicable)	
Phone	
Family Physician	

Reason for Referral:

- ☐ Heart health
- ☐ Weight concerns
- ☐ Disordered eating / Eating disorders
- ☐ Other - please specify: _____

*__For pediatrics, please attach growth/BMI chart if available__.

Diagnosis:

History/Medical/Social Factors:

Medications:

Relevant Lab Reports: – Please Attach

Referral Source: ☐ Physician ☐ Home care nursing ☐ Other - please specify: _____

Name (print): _____ **Date:** _____

For Scheduling Office Only:

Date Received: _____

Appointment Date/Time: _____

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Revised December 2019