



## Dietitian Referral Form

Name: \_\_\_\_\_ Therapist: \_\_\_\_\_

Please contact Central Booking to book an appointment.

**Local: (416) 281-7022    Toll Free: 1-855-448-5471**

Location											
<input type="checkbox"/> <b>Scarborough Health Network - Centenary</b> 2867 Ellesmere Road (Ellesmere Rd and Neilson Rd)  From the main entrance, walk through the lobby and take the elevators to the 11 <sup>th</sup> Floor. Please take a seat in the front lobby area.	<input type="checkbox"/> <b>Home Telephone Appointment</b>  Appointment will be conducted in your home via telephone.										
<p><b>Reason for referral (check all that apply):</b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> High Cholesterol</td> <td><input type="checkbox"/> Pre-diabetes</td> </tr> <tr> <td><input type="checkbox"/> High Triglycerides</td> <td><input type="checkbox"/> Blood Pressure Management</td> </tr> <tr> <td><input type="checkbox"/> Poor Eating Habits</td> <td><input type="checkbox"/> Heart Failure</td> </tr> <tr> <td><input type="checkbox"/> Poor Appetite/Low body Weight</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Overweight/Obesity</td> <td></td> </tr> </table>		<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pre-diabetes	<input type="checkbox"/> High Triglycerides	<input type="checkbox"/> Blood Pressure Management	<input type="checkbox"/> Poor Eating Habits	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Poor Appetite/Low body Weight	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Overweight/Obesity	
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<p>NOTE if you have diabetes or kidney disease please speak with your Exercise Therapist prior to completing a referral form.</p>											
<p>(To be completed after speaking with Central Booking)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><b>My appointment is on:</b></td> <td style="width: 33%;">Day: _____</td> <td style="width: 33%;">Time: _____</td> </tr> <tr> <td><b>My appointment is on:</b></td> <td>Day: _____</td> <td>Time: _____</td> </tr> <tr> <td><b>My appointment is on:</b></td> <td>Day: _____</td> <td>Time: _____</td> </tr> </table>		<b>My appointment is on:</b>	Day: _____	Time: _____	<b>My appointment is on:</b>	Day: _____	Time: _____	<b>My appointment is on:</b>	Day: _____	Time: _____	
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**3 DAY FOOD RECORD**

**Instructions:** Please write down everything you eat for 3 days before your **first** appointment with the dietitian. It does not have to be 3 days in a row. It is best to include 2 week-days and 1 weekend. Eat as normal and only fill out spots as necessary. Be as specific as possible – write down amounts, brands, all ingredients used. If you are unsure, take a picture to show the dietitian.

	Day 1	Day 2	Day 3
Breakfast	Time:	Time:	Time:
Snack	Time:	Time:	Time:
Lunch	Time:	Time:	Time:
Snack	Time:	Time:	Time:
Dinner	Time:	Time:	Time:
Snack	Time:	Time:	Time: