Central East
REGIONAL
CARDIOVASCULAR
REHAB

Dietitian Referral Form

Name: _____ Therapist: _____

Please contact Central Booking to book an appointment.

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

Location

☐ **Scarborough Health Network - Centenary**
2867 Ellesmere Road
(Ellesmere Rd and Neilson Rd)

From the main entrance, walk through the lobby and take the elevators to the 11th Floor.
Please take a seat in the front lobby area.

☐ **Home Telephone Appointment**

Appointment will be conducted in your home via telephone.

Reason for referral (check all that apply):

- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Poor Eating Habits
- ☐ Poor Appetite/Low body Weight
- ☐ Overweight/Obesity
- ☐ Pre-diabetes
- ☐ Blood Pressure Management
- ☐ Heart Failure
- ☐ Other: _____

NOTE if you have diabetes or kidney disease please speak with your Exercise Therapist prior to completing a referral form.

(To be completed after speaking with Central Booking)

My appointment is on: **Day:** _____ **Time:** _____
My appointment is on: **Day:** _____ **Time:** _____
My appointment is on: **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: