UHN Canada's Hospital

Driscoll Family Digestive Health Centre
Toronto Western Hospital
399 Bathurst St, Toronto, ON M5T 2S8
Endoscopy Unit: 4th Floor East Wing

NUTRITION CLINIC REFERRAL FORM

FULLY COMPLETE & FAX TO: 416-603-6204

Referral date:_____
(dd-mm-yyyy)

PATIENT LAST NAME:			PATIENT FIRST NAME:
HEALTH CARD #:	VERSION CODE:		DATE OF BIRTH (DD-MM-YYYY):
☐ SELF PAY			☐ OUT OF PROVINCE PROVINCE: _____
SEX ON HEALTH CARD: ☐ M ☐ F ☐ X	GENDER:		Language Spoken: _____ ☐ Interpreter Required
ADDRESS:			PRIMARY PHONE #:
CITY:	PROV.	POSTAL CODE:	SECONDARY PHONE #:

The Gastroenterology Nutrition clinic provides a consultative service where patients have access to a nutrition assessment along with receive dietary guidance to complement their current GI care. The clinic does not take over the patient's primary gastroenterologist or dietitian care. The patient will continue to follow up with their referring provider.

For enteral feeding support, please consider referring to Ontario Health at Home.
For parenteral nutrition assessments, please contact the Home PN Program at Toronto General Hospital

***DIAGNOSIS (check all that apply - *must be completed):**

	Short bowel syndrome/intestinal failure (not requiring PN)		Inflammatory bowel disease		Pancreatic insufficiency
	Intestinal dysmotility		Post GI surgery malnutrition		Protein-losing enteropathy

***INDICATION (check all that apply – *must be completed):**

	Nutrient deficiencies / Malabsorption		Unintentional, significant weight loss (>5% in 6 months)		Prehabilitation optimization
	High output / Excess losses				

ATTACH ALL RELEVANT INFORMATION

Primary Gastroenterologist: _____

Reports **MUST** be attached to this referral:
☐ Current Medication & Allergy List ☐ Past Medical & Surgical History ☐ Endoscopic & Imaging Reports

REFERRING PROVIDER

NAME:			OHIP BILLING #:
PHONE #:	ADDRESS:		
FAX #:	CITY:	PROV:	POSTAL CODE:

ADDITIONAL COMMENTS FOR REFERRAL:

Date Triaged:	**Book Within: _____ Week (s)/ _____ Month(s)**