intuition nutrition.

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REGISTERED DIETITIAN REFERRAL

Date of referral: _____

Patient Name: _____ Physician Name: _____

DOB: _____ Signature: _____

Phone: _____ Phone: _____

REFERRAL INFORMATION:

Patient aware of referral: ☐ Yes ☐ No

Reason for referral: _____

Physician comments: _____

_____

PLEASE FAX THIS TO 519-204-0729

Below are examples of appropriate referrals reasons:

- ☐ Intuitive Eating
- ☐ Emotional eating
- ☐ Yo-yo dieting/weight cycling
- ☐ Disordered eating behaviours (**NOT active diagnosed eating disorders or suspected eating disorders in <18 yrs old** - please refer these patients to specialized Eating Disorders programs)
- ☐ Pediatric nutrition (over 1 yr olds) - allergies and intolerances, G.I issues, picky eating, lunch packing, general
- ☐ IBS
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Prediabetes or Type 2 DM (**NOT Type 1 or complicated Type 2 DM cases**)
- ☐ PCOS
- ☐ Osteoporosis
- ☐ Fatty liver
- ☐ Diverticular disease
- ☐ Constipation or diarrhea
- ☐ Eating on a budget
- ☐ Prenatal or postnatal nutrition
- ☐ General picky eating (**NOT ARFID** - please send to specialized programs)

PLEASE NOTE: We specialize in helping patients improve their relationship with food and break-free from diet culture through a gentle and supportive non-diet approach that is rooted in Intuitive Eating principles.
If we feel your patient would benefit from another RD in the community, we will let our referral coordinator know so that theymay re-route the referral!
Please do not hesitate to contact me (Jenna) with any questions.