TE MANU TOROA

DIETITIANS SERVICE REFERRAL FORM

Referral Date:	***GP Clinic:***	
	Individuals preferred consultation site:	
Patient Details		
Name:		
Date of Birth:	**NHI number:**	
Address:		
Phone :		
Email:		
Preferred method of contact:		
Ethnicity:		
Reason for referral:		
Weight:	**Height:**	**BMI:**
Co-morbidities:		
Relevant medical history:		
Medications:		
Known Allergies:		
Other considerations: - **Preferred language:** - **Interpreter required:** - **Transport issues:** - **Other:**		
Referrer Details		
Referrer Name:		
Designation:	**Phone:**	
Address:	**Email:**	
Tick all three circles to complete referral.	**O** I have discussed this referral with my patient and they consent and desire to see the Dietitian.	
	O I have discussed this with my patient and they consent to being contacted by the Dietitian.	
	O Please advise individuals at the time of referral that they need to contact the referrer if their condition deteriorates from the time of referral.	

Signature: **Date:**