Referral Form

Personal information of client needing nutritional care:

First name | Last name | Date of birth

Home phone | Mobile phone | Gender

Address | Email

If client is under the age of 19 please complete the following:

Parent or Legal Guardian:

First name | Last name | Relationship to client

Home phone | Mobile phone | Gender

Address | Email

Health Insurance Providers

Please note: Private Practice Registered Dietitians are not covered by Medicare

Health Card Number | Extended Benefits

Medical Information

Medical diagnosis:

Medical history:

Laboratory findings:

Medications:

Other information:

Privacy Policy and Protection of Information: BC dietitians in private practice within BC are governed by the provincial legislation, PIPA. BC dietitians in private practice within BC, but who have clients across provincial boundaries are subject to the Personal Information Protection and Electronic Documents Act (PIPEDA). All organizations that operate in Canada and handle personal information crossing provincial or national borders are subject to PIPEDA. Joy Y. Kiddie, MSc RD can correspond with the client's physician(s) and other health care providers or individuals from named organizations to obtain information relevant to the nutrition treatment and counselling upon a signed release of information. The client must sign a release for the Registered Dietitian to contact the other Health Care Professional they name for the intended purposes to benefit from the care of a Registered Dietitian and to share personal information by letter, phone, fax or email. This referral signed by you implies that you have obtained consent to share the patients information. Any information so obtained by Joy Y. Kiddie, MSc RD will be held in strict confidence for appropriate purposes (i.e. assessing appropriate therapy or communication with you.) Joy Y. Kiddie, MSc RD will keep records of the visits and file these in a secure place, which may include scanning into a PDF or obtained via web form and stored electronically.

☐ By checking off this box, I declare that I have read and understand this form and that my typed name below is as legally binding as my physical signature.

Referring Physician/Clinician:

Date:

Print Name: | Phone:

Clinic: | Fax:

Address | Email:

Office Stamp:

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Registered Dietitian

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