ISLAND NUTRITION
Registered Dietitians

Please email referrals to reception@islandnutrition.bm or fax to 295-5245

Date _____

Patient Name _____ D.O.B. __DAY__ MONTH __YEAR__

Name of contact person and relationship (if not patient) _____

Phone numbers _____(C) _____(H) _____(W)

Email address _____

Insurance provider/Information _____

Referral for:

- ☐ 1:1 Consults
- ☐ Intensive Individualised Cardiovascular Disease & Weight Management Structured Education Program (12 weeks)
- ☐ X-PERT Prevention and Management of Diabetes Group Program (6 weeks, once weekly x 2.5 hours)
  (General groups, family groups and workplace groups are available)
- ☐ Home Visit Parish _____ Please indicate any safety concerns for RD _____
- ☐ Other: Please state _____

Reason for referral/presenting problem _____

ICD-10 Codes _____

Past Medical History (please give all relevant past/current diagnoses) _____

_____

Recent relevant labs (please write or send with referral) _____

_____

Current medications (please write or send with referral) _____

_____

Height _____ Weight _____ BMI _____

(Please attach growth charts if referral is for a child) *(Please note children should attend appointments with an appropriate adult)*

Comments _____

_____

_____

Referring Physician (PRINT) _____ (SIGN) _____

Physician contact EMAIL for reports _____

Phone number _____ Fax number _____