THE UNIVERSITY OF AUCKLAND
CLINICS

Nutrition and Dietetic Clinic
REFERRAL FORM

NUTRITION AND DIETETIC CLINIC REFERRAL FORM

CLIENT DETAILS

Name: _____ Phone: _____
Address: _____
D.O.B.: _____ Gender: _____ NHI: _____
Ethnicity: _____ Language: _____
G.P.: _____

REFERRAL INFORMATION

Date referred: _____

Referred by: Name: _____ Position: _____

Address: _____

Dietitian review timeframe:
☐ Urgent, within 2 weeks ☐ Within 1 month ☐ Any available appointment

Issues of concern:
_____
_____
_____
_____

OPTIONAL / ADDITIONAL INFORMATION

Weight: _____ Height: _____ Weight change in last 6 months: _____
Appetite: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Gastrointestinal concerns: _____
Relevant biochemistry (date): _____
Medical history: _____
_____
Pertinent medications: _____
_____
Comment: _____
_____
_____
_____

PLEASE EMAIL THE COMPLETED FORM TO: nutritionclinic@auckland.ac.nz
Alternatively please:
POST TO: The University of Auckland Clinics
Private Bag 92019
Glen Innes 1142
ATTN: NUTRITION AND DIETETIC CLINIC
FAX TO: 09 3035978

FOR CLINIC ADMINISTRATION USE ONLY:

Date referral received: _____ Received by: _____
Invoice code: _____ Referral code: _____