DIETITIAN REFERRAL FORM – Inpatient

Facility: ___________________________
Room Number: ____________________
DATE OF ADMISSION:_____________________ HEIGHT:_________ WEIGHT:_________
DIAGNOSIS:____

☐ ADULT NURSING ADMISSION HISTORY NUTRITION SECTION INDICATES NUTRITION RISK: (2 "YES" ANSWERS)

RELEVANT MEDICAL INFORMATION (PLEASE INCLUDE TREATMENT RECOMMENDATIONS OR ANY CONTRA-INDICATIONS):

Information required to assist in prioritizing referrals for Dietitian/Nutrition Services:
(Check all appropriate boxes)

☐ **Priority 1 (High Risk)**	☐ **Priority 2 (Moderate Risk)**	☐ **Priority 3 (Low Risk)**
☐ Significant weight change (per Inpatient Dietitian Referral form guideline) ☐ New Enteral Nutrition (Tube Feed/TPN) ☐ NPO > 5 days ☐ Clear Fluids or minimal intakes > 5 days ☐ < 50% intakes > 7 days ☐ Excessive/Inadequate fluid intakes ☐ Malabsorption (excessive emesis/diarrhea/high ostomy losses) ☐ Increased nutrient needs ○ Presence of open wound ☐ Starting Modified texture or fluids ☐ Abnormal nutrition-related labs ○ Hypo/hyperkalemia ○ Hypo/hypernatremia ○ Hypo/hyperphosphatemia ○ Hypo/hypermagnesmia ☐ Nutrition Education required for immediate discharge	☐ Hyperglycemia ☐ NPO for 4 days ☐ Clear Fluids or minimal intakes for 4 days ☐ < 50% intakes > 5 days ☐ Increased nutrient needs ○ Superficial wound ☐ Re-evaluate existing Tube Feed/TPN ☐ Re-evaluate existing modified texture/liquid diet ☐ Education for new diagnosis ○ Celiac ○ Diverticulosis ○ Inflammatory Bowel Disease (Ulcerative Colitis/Crohn's) ○ Diabetes	☐ Weight management ☐ Pre-existing chronic disease with previous teaching ☐ Unintended weight gain on Tube Feed/TPN ☐ NPO < 3 days ☐ Clear Fluid or minimal intake < 3 days ☐ < 50 % intakes < 5 days ☐ Food preferences (or diet preference) ☐ **Other (Please specify below)**

☐ For small acute hospitals - Scan via Xerox and direct email to Clinical Dietitian providing coverage. File original in patient chart.
☐ For Regional Centres - Scan via Xerox and direct email to site Clinical Dietitian, or off-site RD providing coverage. File original in patient chart.

Referral Source Signature: ____

Physician's Name: (print)_______________________________________ **Date**:_________________________________

Date Referral Reviewed by Dietitian:____________________________ ☐ Priority 1 ☐ Priority 2 ☐ Priority 3