

PRIORITY ALLIED HEALTH SERVICES

DIETETICS

REFERRAL FORM



Patient to be seen by: Help Yourself Nutrition & Dietetics

- ☐ Great Lakes LGA
 ☐ Forster-Tuncurry
 ☐ Gloucester LGA
 ☐ Taree
 ☐ Wingham

Referral Date:			
Referring GP:		Provider No:	
GP Contact Details:	Tel:	Fax:	
Patient Name:			
Patient DOB:		Male	Female
Patient Address:			
Patient Telephone(s):	(h)	(m)	
Medicare/DVA number:			
Consent:	Has the patient consented to this referral? Yes No		
ATSI:	No	Aboriginal	Torres Strait Islander Unknown
Educational status:	Primary Secondary (Yr 10 equivalent) Secondary (Yr 12 equivalent) Tertiary Unknown		
Living arrangements:	Lives Alone	Family / Carer	Friend Unknown
Reason for Referral: <div style="display: flex; justify-content: space-between;"> <div> Cardiac Dysphagia/Modified consistency Enteral Feeding-Nasogastric/PEG Gestational Diabetes Pediatric _____ Recently Diagnosed Diabetes Unstable Diabetes </div> <div> Diagnosed Food Allergy/Intolerance Eating Disorder Gastrointestinal Obesity/overweight +co-morbidities Prolonged Wound Healing or infection Renal/Hepatic Failure Other (Specify) _____ </div> </div>			
GP signature:			

Please fax this referral form to: Help Yourself Nutrition & Dietetics
Fax : 1300 654 885 **Ph:** 1300 652 620
Email: info@helpyourself.com.au
Mail Address: PO Box 259, The Junction NSW 2291