HUMBER RIVER HOSPITAL

Maternal & Child Program
Paediatric Outpatient Clinic

Paediatric Nutrition Clinic

1235 Wilson Avenue, Toronto, ON, M3M 0B2
Phone: 416-242-1000 ext 21400 **Fax: 416-242-1095**

All referrals for the Nutrition Clinic are for a Registered Dietitian. Referrals may include a Pediatrician or Occupational Therapist (OT) consult as required. Referrals will be triaged according to risk, therefore include as much detail as possible. We **DO NOT** accept referrals for clinical eating disorders.

Client Information:

Name:		Date of Birth: day/month/year	Male or Female
Address:	City:		Postal Code:
OHIP #:	Version Code:	Parent Name:	
Home Phone Number:	Mobile Phone Number:		
email(s):			
Referred By: Billing No:		Phone Number:	

Diagnosis & Medical History:

Detail **all** medical history (for example include history of reflux, constipation, if has had developmental assessment, etc.)

Reasons for Referral: Check all boxes that apply

- ☐ BMI for Age >97th percentile
- ☐ Weight for Length >97th percentile
- ☐ BMI for Age <3rd percentile
- ☐ Weight for Length <3rd percentile
- ☐ Altered growth velocity i.e. moved 2 percentile curves away from usual
- ☐ Sensory feeding challenges
- ☐ Food texture not age appropriate
- ☐ Excessive gagging/vomiting
- ☐ Food selectivity i.e. eats less than 15 different foods and not all food groups represented
- ☐ Hyperlipidemina
- ☐ GI issues (constipation, reflux)
- ☐ Nutrient deficiency (iron, etc)
- ☐ Vegan, vegetarian, restricted diet
- ☐ Multiple food allergies
- ☐ Other: _____

Additional Comments:

Feeding and Medical History:

Current weight:	Height:	BMI:	Birth weight:	Birth length:

Growth charts required. Attach to referral.

Abnormal Lab Values (attach recent labs):

Current Medications and dosage:

Referring Physician Signature: _____ Date: _____

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