THE UNIVERSITY OF AUCKLAND
CLINICS

Nutrition and Dietetic Clinic
REFERRAL FORM

NUTRITION AND DIETETIC CLINIC REFERRAL FORM

CLIENT DETAILS

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

REFERRAL INFORMATION

Date referred: _____

Referred by: Name: _____ Position: _____

Email: _____

Appointment preferences
Preferred day(s): Tuesday ☐ Wednesday ☐
Preferred time(s): 9am ☐ 10am ☐ 11am ☐ 12pm ☐

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: clinics@auckland.ac.nz
Alternatively please:
POST TO: The University of Auckland Clinics
28 Park Avenue
Grafton, Auckland 1023
ATTN: NUTRITION AND DIETETIC CLINIC
Phone: 09 9239909

FOR CLINIC ADMINISTRATION USE ONLY:

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

Updated: Jan 2025