THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

CLINICS
NUTRITION AND DIETETIC

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: clinics@auckland.ac.nz

FOR CLINIC ADMINISTRATION USE ONLY:

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