



Community Dietitian Referral

Patient:
Address:

PHIN:

MHSC:

DOB (d/m/y):

Phone: Home: Work:
Cell:

Physician:
Clinic:

Refer patient to TeleCare Manitoba (fax: 1-204-779-5645) if they meet the following criteria:

- ◆ Over the age of 18
- ◆ Diagnosed with type 2 diabetes with an A1C of <9% and taking 2 or less oral agents (not on insulin) **OR** diagnosed with pre-diabetes **OR** one or more of the following risk factors: strong family history of diabetes, history of gestational diabetes mellitus (GDM) or diabetes in pregnancy
- ◆ Not currently pregnant at time of enrolment
- ◆ Functionally able to participate in telephone based health care delivery

If you do not want your patient referred to TeleCare Manitoba, check this box:

Clinical Information / Medical History

WT: _____ Date: _____ Ht: _____

<input type="checkbox"/> Diabetes (use Diabetes Program Referral)	<input type="checkbox"/> Post MI	<input type="checkbox"/> Cancer	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> IGT/IFG (Pre-Diabetes)	<input type="checkbox"/> CVA	<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Food Allergy / Intolerance
<input type="checkbox"/> At risk for Diabetes	<input type="checkbox"/> Nephrotic Syndrome	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Malnutrition
<input type="checkbox"/> Reactive Hypoglycemia	<input type="checkbox"/> Pre-Dialysis	<input type="checkbox"/> Colitis	<input type="checkbox"/> Nutrient Deficiency
<input type="checkbox"/> Obesity	<input type="checkbox"/> Renal Failure without Dialysis	<input type="checkbox"/> IBS	<input type="checkbox"/> Unexplained Weight Loss
<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Diverticular Disease	<input type="checkbox"/> Open Area / Wound
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Fatty Liver	<input type="checkbox"/> Short Bowel	Location _____
	<input type="checkbox"/> Liver Cirrhosis	<input type="checkbox"/> GERD	Size / Stage _____
			<input type="checkbox"/> Other: _____

Reason for Referral:

- Attach copy of pertinent lab work and medications with referral form.
- Special Considerations: hearing impaired visually impaired other _____

Referring Physician/Professional Signature: _____ Date: _____

Referral Protocol

For community clients who require nutrition counselling, complete this form and fax or forward to:	Fax	Office Location
<input type="checkbox"/> Altona	324-1299	Altona Health Centre
<input type="checkbox"/> Carman	745-2756	Carman Memorial Hospital
<input type="checkbox"/> Crystal City	873-2185	Rock Lake Health District
<input type="checkbox"/> Emerson	373-2748	Emerson Health Centre
<input type="checkbox"/> Gladstone	385-2663	Gladstone Health Centre
<input type="checkbox"/> MacGregor Health Centre	685-2529	MacGregor Health Centre
<input type="checkbox"/> Manitou	331-8801	Pembina-Manitou Health Centre
<input type="checkbox"/> Morden *	822-6886	Agassiz Medical Centre
<input type="checkbox"/> Morris	746-2197	Morris General Hospital
<input type="checkbox"/> Notre Dame	248-2299	Centre Albert-Galliot
<input type="checkbox"/> Portage/ Elie/ Headingly	856-2045	204-140 9 th St SE, Portage la Prairie
<input type="checkbox"/> Somerset	744-2511	Somerset Place
<input type="checkbox"/> St. Claude	379-2655	St. Claude Pavillion
<input type="checkbox"/> Swan Lake	836-2123	Lorne Memorial Hospital
<input type="checkbox"/> Winkler *	325-4594	Dr. C. W. Wiebe Medical Centre

*Clients must have a family physician at these clinics in order to be seen by the clinic dietitian. If not, fax referral to BTHC clinical dietitian at 331-8801.