PATIENT LABEL

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NUTRITION ADVISING REFERRAL FORM

(For self referral and physician referral)

1. PATIENT INFORMATION: (Please print clearly and provide as much information as possible in this section. If the information is not complete, we may not be able to process and complete your request).

Last Name: _____ First/Given Name: _____ Middle Initial: _____

Previous Surname (if applicable): _____ Date of Birth (YEAR/MONTH/DAY) _____

Provincial Health Card number_____ Province card issued in: _____

Mailing address (street # / unit # / apartment #) _____

Mailing address (city / Province / postal code) _____

Daytime telephone number with area code: _____

2. REASON FOR REFRRAL: PLEASE CHECK IF THIS IS A SELF REFERRAL

3. PHYSICAL ACTIVITY (include approximate amount of time for each activity)

4. REFERRING PHYSICIAN: _____

SIGNATURE: _____

DATE: _____ **MSVU OFFICE STAMP:**

5. Patient signature: _____

Date: _____

Form is to be returned to the MSVU Health Office where it will then be sent to MSVU Student Nutrition Services for review, student.nutrition@msvu.ca. If it is felt this is not a referral for Student Nutrition Services, the Health Office will contact you and offer a doctor's appointment. Otherwise, Student Nutrition Services will contact you to schedule a meeting time.