calgary health region
Alberta Children's Hospital

Doctor's Referral Letter
Feeding Consultation Service

Please fill in this referral form as completely as possible in order to facilitate' proper management and scheduling,

Please Attach Growth Chart

Name ______________________________
Last First

DOB ______________________________
yyyy / mm / dd

Patient ID # ______________________

Referral To: **Feeding Consultation Service**
Clinical Nutrition
Phone: 403-955-7294 Fax: 403-955-3261

Referral Date ______________________

Name(s) of Parents / Guardian	Home Phone	Business Phone
Address		Postal Code
Patient's A.H.C.I. Number	Diagnosis	

Reason For Referral

- ☐ decreased growth velocity
- ☐ history of suspected aspirations
- ☐ oral pharyngeal dysfunction and/or swallowing difficulty
- ☐ consideration to/from tube feeding
- ☐ other ______________________

Recent Health History

Developmental History

Other Perinent Information

Other Clinics/Agencies

Referring Physician (Please Print)		Physician's Signature
Address		Phone
City	Province	Postal Code

This referral has been received and the following action taken:

☐ Waiting List	Estimated Length of Wait
☐ Redirected to	

Person Receiving Referral	Name	Signature	Date