Phone: (02) 9382 1021
Fax: (02) 9382 1200
Address: Nutrition & Dietetics Dept.
Sydney Children's Hospital,
High St, Randwick 2031

Referral to Dietetic General Outpatient Clinic

Name of referring Doctor_____Phone:_____

Doctors Address_____Fax:_____

Medicare Provider Number (for non SCH medical staff) _____

Patient's Name_____

Patient's Address_____

_____ Phone: _____

MRN (if applicable)_____ DOB (please note if premature)_____

Current height (cm)_____(Please include copy of growth chart)

Current bare weight (kg)_____

Reason for referral: *(Please note referrals must meet one of the following criteria)*

- ❑ FTT (as evident from recent heights and weights plotted on a growth chart) *
- ❑ Vitamin or mineral deficiency (Confirmed by a blood test) *
- ❑ Confirmed food allergy (Please provide a copy of test results) *
- ❑ Enterally fed child
- ❑ Above the 85th percentile for BMI and less than 4 years old
  (as evident from height and weights plotted on a CDC BMI growth chart) *
- ❑ Above the 85th percentile for BMI and interpreter is required.
  Interpreter language required _____
  (as evident from height and weights plotted on a CDC BMI growth chart) *

For local GP referrral's (non SCH medical staff) – the patient must also reside in the local health district

- ❑ Patient resides in postcodes 2000, 2010-2011, 2015, 2017-2036

* NO APPOINTMENT WILL BE MADE UNTIL A COPY OF THIS INFORMATION HAS BEEN RECEIVED

Detailed reason for referral_____

_____

_____

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_____

Relevant medical / social history_____

_____

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_____

_____

DATE _____ Referring Doctor's Signature_____