To: Carmela Lee
Registered Dietitian (UK)
Room 1506 & 09, 15/F
Office Tower 2
Grand Plaza
625 & 639 Nathan Road
Mongkok
Tel: 2185 6642

From: *(Doctor's chop showing Name and Tel. #)*

Date: _____

Dietetic Service Referral Form

I would like to refer the following patient for your nutritional assessment and treatment.

Patient's Name: _____

HKID: _____

Diagnosis: _____
_____

Relevant Medication & Lab. Results: _____
_____

Past Medical Hx: _____
_____

Reason(s) for Referral:

☐ Pregnancy	☐ DM	☐ Nutrition support	☐ Cancer
☐ Infant growth	☐ HT	☐ Obesity	☐ Renal
☐ Child growth	☐ Lipid	☐ Others:	