Health
South Eastern Sydney
Local Health District

Nutrition & Dietetics Paediatric Referral Form

Date: ___/___/____

Name of referrer: _____ Phone: _____

Managing Doctor (Paediatrician or GP):_____

Patient's Name: _____

Parent's Name: _____ Phone: _____

Address: _____

MRN (if applicable): _____

DOB (note if premature): _____

Current height: _____

Current bare weight: _____

Reason for referral:

- ☐ Failure to thrive i.e. a decline in 2 or more centile lines OR weight for length/BMI less than the 5th centile. Copy of growth charts must be included.
- ☐ Tube feeding
- ☐ Fussy eating with confirmed nutrient deficiency. Note: a copy of biochemistry must be included (we do not accept general fussy feeding referrals)
- ☐ Diagnosed food allergy
- ☐ Persistent constipation i.e. not improved with aperients and simple diet education
- ☐ Overweight or obese children <6 years (BMI > 85th %ile) – *7 sessions offered.*
  - If 7-13 years refer to Go4Fun, if >13 years refer to TEAM.
- ☐ Other (as deemed appropriate by paediatrician e.g. coeliac disease, IBD, EoE etc.) _____

Additional Information (relevant medical and social history, medications, allergies, interpreter required etc.):

_____

_____

_____

Please fax or email this referral to our office, we will arrange an appointment and notify the parents of the date and time.

Department of Nutrition & Dietetics
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2nd Floor, Prichard Wing
KOGARAH NSW 2217

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