Free exploratory call
Phone: 1-877-260-5535
Fax: 1-514-221-3116
contact@teamnutrition.ca

Nutrition Consultation Request

Patient Information

Last Name:	First Name:
Date of birth (DD/MM/YYYY):	Phone:
City/Clinic:	

Reason for Nutrition Consultation

- ☐ Allergies/Intolerances
  Specify:
- ☐ Nutritional Deficiency
- ☐ Weight Management
- ☐ Chronic Diseases
  - ☐ Diabetes
  - ☐ Dyslipidemia
  - ☐ Fatty Liver Disease
  - ☐ Gout
  - ☐ Hypertension
- ☐ Digestive Disorders
  - ☐ Celiac Disease
  - ☐ Crohn's Disease
  - ☐ Diverticulosis/Diverticulitis
  - ☐ Gastroesophageal Reflux Disease
  - ☐ Irritable Bowel Syndrome
  - ☐ Ulcerative Colitis
- ☐ Eating Disorders
  Specify:
- ☐ Other:

Additional Information:

Referring Healthcare Professional Information

Last Name:	First Name:
Fax:	Email:
License #:	Signature:

I would like to receive a summary of the patient's nutrition management. ☐ Yes ☐ No

The patient is covered by private insurance. ☐ Yes ☐ No ☐ Unknown

teamnutrition