

Registered Dietitian

Intake form

Please complete this form and email to: info@pccfht.ca. Please call Family Health Team Reception at 519-442-9834 to book.
Please complete all applicable fields and select all reasons for your appointment.

Patient information

Full Name

Date of Birth (YYYY-MM-DD)

Health Card Number and Version Code

Phone Number

Address (including postal code)

Email Address

Family Physician / Nurse Practitioner

☐ I do not have a Family Physician / NP.

Reason for appointment

Select all that apply. We do not offer a formalized weight loss program.

- | | |
|---|---|
| ☐ High cholesterol | ☐ Infant nutrition (e.g., starting solids) |
| ☐ High blood pressure | ☐ Toddler / preschool nutrition |
| ☐ Fatty liver | ☐ School-age child nutrition |
| ☐ Prediabetes | ☐ Pregnancy nutrition |
| ☐ Type 2 diabetes | ☐ Weight concerns |
| ☐ IBS (irritable bowel syndrome) | ☐ Vegetarian / vegan nutrition |
| ☐ Crohn's disease / colitis | ☐ Disordered eating |
| ☐ Celiac disease | ☐ General healthy eating |
| ☐ Osteoporosis | ☐ Other (please specify below) |

Other reason / relevant medical conditions

Please complete Consent and Acknowledgment on page 2.

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Full Name (to identify this page)

Consent and Acknowledgment

I understand that the recommendations provided by the Registered Dietitian are intended to support my health and nutrition goals and do not replace, override, or modify the medical advice, diagnosis, treatment plan, or prescribed medications provided by my physician or other qualified healthcare provider.

If my physician has provided specific medical instructions, dietary restrictions, or a treatment plan, I acknowledge that it is my responsibility to consult with my primary care provider before making any changes based on the Registered Dietitian's recommendations. I understand that I should continue to follow my primary care provider's advice unless otherwise directed by my primary care provider.

May the PrimaCare Registered Dietitian request and share relevant health information with the Physician / NP named above, if necessary, to coordinate my nutrition care?

☐ Yes ☐ No

Patient / Substitute Decision-maker Signature (Sign or Type Name)

Date (YYYY-MM-DD)