fraserhealth

Licensing Registered Dietitian Referral Form

FACILITY INFORMATION	
FACILITY NAME	BUSINESS TELEPHONE NUMBER ( )
FACILITY ADDRESS STREET CITY POSTAL CODE	E-MAIL ADDRESS
APPLICANT'S NAME	TELEPHONE NUMBER ( )
APPLICANT'S SIGNATURE	DATE (dd/mmm/yyyy)

SECTION A: To be completed by the Applicant

Please check ☑ the following which applies:

Size of facility and staffing qualifications

- ❑ 24 or fewer persons in care – Registered Dietitian required if screening form indicates a need for one
- ❑ More than 24 persons in care – Registered Dietitian required for care planning
- ❑ 50 or more persons in care – Nutrition Manager with Membership in Canadian Society of Nutrition Managers* or Registered Dietitian required for supervising food services
- ❑ If persons in care may require tube-feeding – Registered Dietitian has Reserved Act A*

- ❑ Meals and More Manual to be used
- ❑ Audits and More Manual to be used

Please submit the following at least 30 days prior to the Licensing Registered Dietitian inspection.

Menu

- ❑ 4 week menu cycle with 3 food groups from the Canada's Food Guide and a minimum of 2 snacks containing 2 food groups from the Canada's Food Guide
- ❑ Completed menu audit

Policies

- ❑ Nutrition monitoring policies

Emergency Plan

- ❑ Emergency Plan for food services (facility-specific)

*** Proof of Credentials**

- ❑ Nutrition Manager (if applicable)
- ❑ Reserved Act A (if applicable)

SECTION B: To be completed by the Licensing Officer (Reason for referral)

- ❑ New Facility – Initial inspection required
- ❑ Structural Change (impacts food service)
- ❑ Review of Transition Plan During a Change in Premise (specific to foodservices)
- ❑ New Licensee – Existing Facility

REFERRED TO LICENSING REGISTERED DIETITIAN (PRINT NAME)

EXISTING LICENCE CAPACITY	PROPOSED LICENCE CAPACITY

- ❑ Long Term Care
- ❑ Mental Health
- ❑ Hospice Care
- ❑ Acquired Brain Injury
- ❑ Community Living BC
- ❑ Child and Youth
- ❑ Other _____

REFERRED BY LICENSING OFFICER OR DEVELOPMENT COORINDATOR (PRINT NAME)

TELEPHONE NUMBER	DATE OF REFERRAL (dd/mmm/yyyy)
( )	

SECTION C: To be completed by the Licensing Registered Dietitian

- ❑ Approved
- ❑ Not Approved

Comments:

Signed: _____ Date: _____