

FULL CIRCLE NUTRITION NUTRITION CONSULT REFERRAL FORM

Please complete and fax to dietitian:

Referred name(s): _____ ICD-9 Dx Code(s) _____
Phone: _____ Address: _____
City: _____ State TX Zip: _____ Age: ____ Years since Dx? ____

Has referred patient received MNT, Nutrition Education / Intervention before? Yes / No

Insurance Type _____ or _ Private Pay.

Referred By: _____ MD DO PA _____
Practice/group Name: _____ Phone: _____
Address: _____ City: _____ State ____ Zip: _____

Patient is Referred for:

Individual Medical Nutrition Therapy Frequency _____
 Nutrition Education Class Duration _____
 Weight loss
 Weight Gain

Diabetes type 1 type2

- hyperglycemia
- hypoglycemia
- carb counting
- meal planning
- syndrome X
- prevention

Cardiovascular

- hyperlipidemia
- high triglycerides
- low HDL
- Hypertension
- fluid restrict _____ml
- Na+ restrict ____g/day

Hepatic

- NASH
- Hepatic Diet

Renal

- protein restrict _____g/day
- Na+ restrict g/day
- K+ restrict _____g/day
- low oxylate diet
- ESRD
- fluid restrict _____ml

GI

- IBS
- crohn's
- celiac
- constipation
- diarrhea
- diverticulitis

Other

- COPD
- Gastric Bypass / Lap band
- _____

When is the consult needed? A.S.A.P < 2 Weeks within 1-2 Months

With patient permission, send nutrition consult report to: office address fax to _____

(Signature)

Referral Date