Referral Form for Outpatient Dietitian

**Fax** this form to Central Scheduling at 806-351-5145

**Call** this number to schedule an appointment 806-354-1701

Date: \_\_\_\_\_\_\_\_\_

Patient Information

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | | DOB: | Gender: |
| Ht: | Wt: | Address: | |
| Phone Number: | | Address line 2: | |
| Preferred Language: | | City, State, Zip Code: | |
| Insurance information: | | | |
|  | | | |

Medical Diagnosis (check all that apply):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | E10.\_ | Type 1 diabetes mellitus |  | K21.9 | Gastroesophageal reflux without esophagitis |
|  | E11.\_ | Type 2 diabetes mellitus |  | K50.\_ | Crohn’s Disease \_\_\_ |
|  | E43 | Unspecified severe protein-calorie malnutrition |  | K57.\_ | Diverticular disease of intestine |
|  | E44.\_ | Protein-calorie malnutrition of moderate and mild degree |  | K58.\_ | Irritable bowel syndrome (IBS) |
|  | E46 | Unspecified protein-calorie malnutrition |  | K90.0 | Celiac Disease |
|  | E66.0\_ | Obesity due to excess calories |  | N18.\_\_ | Chronic Kidney Disease, stage \_\_ |
|  | E66.3 | Overweight |  | O24.41\_ | Gestational diabetes in pregnancy |
|  | E66.9 | Obesity, unspecified |  | O26.1\_ | Low weight gain in pregnancy |
|  | E78.0 | Pure hypercholesterolemia |  | R62.51 | Failure to thrive (child) |
|  | E78.1 | Pure hyperglyceridemia |  | R62.7 | Adult failure to thrive |
|  | E78.2 | Mixed hyperlipidemia |  | R63.3 | Feeding difficulties |
|  | E88.9 | Metabolic disorder, unspecified |  | R63.4 | Abnormal weight loss |
|  | G47.33 | Obstructive sleep apnea |  | R63.5 | Abnormal weight gain |
|  | I10 | Essential (primary) hypertension |  | R63.6 | Underweight |
|  | J45.909 | Unspecified asthma, uncomplicated |  | \_\_\_\_\_ | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | K21.0 | Gastroesophageal reflux with esophagitis |  |  |  |

\*Please attach most recent progress notes, labs, and medications as appropriate.\*

Referring Physician/provider (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician/provider signature (Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_