NOVA SOUTHEASTERN UNIVERSITY | NSU Florida

Patient Referral for Nutrition Clinical Practice

I. Patient Information:		
Date:	Clinic Contact:	
Patient's Name:		DOB:
Guardian's Name (if applicable):		
Patient's Home Phone:	Cell/Second Number:	
Name of Referring Provider:		
Office Phone:	Office Fax #:	
Note* Sending a patient data sheet is appreciated.		

II. Diagnosis with ICD 10 (Please check all that apply):			
Adults		**Pediatrics**	
	Diabetes (E10.__ or E.11__)		Overweight (E66.3)
	Pre-Diabetes (R73.03)		Obesity (E66.9)
	Obesity (E66.9)		Abnormal weight gain (R63.5)
	Abnormal weight gain (R63.5)		BMI, greater than 95th % (Z68.54)
	Abnormal weight loss (R63.4)		Failure to thrive (R62.51)
	Hypoglycemia (E16.2)		Abnormal weight loss (R63.4)
	Hypertension (I10.0)		Underweight (R63.6)
	Hyperlipidemia (E778.5)		BMI, less than 5th % (Z68.51)
	Hypothyroidism (E03.9)		Breastfeeding difficulty (P92.5)
	Chronic kidney disease (N18.1-4)		Anemia (D64.9)
	Polycystic ovarian syndrome (E28.2)		Food allergy: ___________________
	Diverticulosis (K57.1 or 3)		Bulimia nervosa (F50.2)
	Crohn's disease (K50.9)		Anorexia nervosa (F50.0)
	Other:		Other:

III. Prescription for Medical Nutrition Therapy *(Please check all that apply)*	
	Dietary Counseling and Surveillance (Z71.3)
	RX per Dietitian
Comments:	

_______________________________ _________________________

Signature of provider Date

Thank you for the referral! The contents of this facsimile are confidential and are intended to be viewed only by the recipient named above. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this information is prohibited. If you have received this fax in error, please notify the sender immediately and destroy all hard copies of the communication.