

## Nutrition Referral Form - Elise Liu, RD, MPH

Patient name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Email: \_\_\_\_\_ DOB: \_\_\_\_\_

Please check all diagnoses that apply to this referral, write in additional below. Thank you.

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|--|--|
| <input type="checkbox"/> Abnormal Wt Gain: R63.5                                   | <input type="checkbox"/> Hypercholesterolemia/Pure: E78.00   |
| <input type="checkbox"/> Amenorrhea: N91.2   | <input type="checkbox"/> Hyperlipidemia/Unspec: E78.5        |
| <input type="checkbox"/> Anorexia Nervosa/Restricting: F50.01                      | <input type="checkbox"/> Hyperlipidemia/Other: E78.4         |
| <input type="checkbox"/> Anorexia Nervosa/Binge/Purge: F50.02                      | <input type="checkbox"/> Hyperlipidemia/Mixed: E78.2         |
| <input type="checkbox"/> Anorexia Nervosa/Unspecified: F50.00                      | <input type="checkbox"/> Hypertriglyceridemia/Pure: E78.1    |
| <input type="checkbox"/> Avoidant/restrictive food intake disorder (ARFID): F50.89 | <input type="checkbox"/> Hypertension/Essential/Primary: I10 |
| <input type="checkbox"/> Binge Eating Disorder: F50.81                             | <input type="checkbox"/> Hypertension w/out CHF: I11.9       |
| <input type="checkbox"/> Bulimia Nervosa: F50.2                                    | <input type="checkbox"/> Impaired Fasting Glucose: R73.01    |
| <input type="checkbox"/> Celiac Disease: K90.0                                     | <input type="checkbox"/> Irritable Bowel Syndrome: K58.0     |
| <input type="checkbox"/> Diabetes type 1 w/out complications:E10.9                 | <input type="checkbox"/> Malnutrition/mild: E44.1            |
| <input type="checkbox"/> Diabetes type 2 w/ hyperglycemia: E11.65                  | <input type="checkbox"/> Malnutrition/moderate: E44.0        |
| <input type="checkbox"/> Diabetes type 2 w/out complications:E11.9                 | <input type="checkbox"/> Obesity/NOS: E66.9                  |
| <input type="checkbox"/> Eating Disorder NOS: F50.9                                | <input type="checkbox"/> Overweight: E66.3                   |
| <input type="checkbox"/> Failure to Thrive/Adult: R62.7                            | <input type="checkbox"/> Polycystic Ovarian Syndrome: E28.2  |
| <input type="checkbox"/> Failure to Thrive/Child: R62.51                           | ICD 10: _____  |
| <input type="checkbox"/> Food Allergies: K52.2                                     | <input type="checkbox"/> Diagnosis: _____                    |
| <input type="checkbox"/> Gestational DM/diet controlled: O24.410                   | ICD 10: _____  |
|  | <input type="checkbox"/> Diagnosis: _____                    |

*The above is for medical nutrition therapy as a necessary part of medical treatment and prevention for the diagnoses listed. The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute the delivery of patient services. Please understand as a link in the "Chain of Trust," all PHI will remain confidential as mandated by the Treatment, Payments and Healthcare Operation Laws mandated by HIPAA.*

Referring Physician Stamp/Write In

Physician's Signature: \_\_\_\_\_ Print MD Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_