Eat Right. Live Right.

Outpatient Nutrition Referral Form

Phone: (315) 624-4600 Fax: (315) 624-4611

ERLR Use Only:
Appt Date:__________
Time:___________

Patient Name:______________________________ **DOB:**____________________

Patients Address:____

______________	________	______________	____________
Patient's Home Phone	**Cell Phone**	Primary **Insurance Provider**	**Insurance ID #**
______________		______________	____________
Name of Parent if Patient is < 18 y.o.		**Secondary Insurance Provider**	**Insurance ID#**

Diagnosis(es) for Medical Nutrition Therapy

(Include ICD-10 codes and list according to the highest level to specificity

____

Medical History:
____
____

Medications:____

Weight:___________ **Height:**_____________ **BMI:**____________

Labs : **Date of Labs:**_________

Bun: ____ **Creatinine:**____ **Sodium:**____ **Potassium:**____ **Albumin:**____

GFR_____ **HGB A1C**_____

Total Cholesterol: _____ **HDL:**_____ **LDL:** _____ **Triglycerides:**____

Exercise Restrictions (if any): ____

______________________________________ ___________ _______________
Physician Signature(Stamps and co-signed signatures are not acceptable) Date DEA Number

______________________________________ _______________
Physician's Address Physician's Office Contact Person Phone Number

____
Fax Number

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