Eat Right. Live Right.

Outpatient Nutrition Referral Form

Phone: (315) 624-5208 Fax: (315) 624-4877

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