



Medical Nutrition Consultation

Physician Referral Form

Phone: (814) 877-2123 Fax: (814) 455-9440

1700 Peach Street, Erie

303 Chestnut Street, Meadville

Patient Name _____ DOB _____

Phone _____ Address _____

Billing Address (if different than above): _____

Referring Physician Name _____

Insurance/Primary _____ ID _____

Insurance/Secondary _____ ID _____

Authorization # _____ Height _____ Weight _____

Recent lab report which indicates diagnosis: (Please complete or fax most recent lab report.)

Cholesterol _____ HDL _____ LDL _____ Trig _____

A1C _____ Other: _____

Comments _____

Diagnosis:

- | | | | |
|--|-------------|---|--------|
| <input type="checkbox"/> Abnormal weight gain | 783.1 | <input type="checkbox"/> Loss of weight | 783.21 |
| <input type="checkbox"/> Constipation | 564.0 | <input type="checkbox"/> Obesity | 278.00 |
| <input type="checkbox"/> Diarrhea | 787.91 | <input type="checkbox"/> Morbid obesity | 278.01 |
| <input type="checkbox"/> Dysphagia, unspecified | 787.2 | <input type="checkbox"/> Overweight | 278.02 |
| <input type="checkbox"/> Failure to thrive | 783.41 | <input type="checkbox"/> Underweight | 783.22 |
| <input type="checkbox"/> Gastroesophageal reflux | 530.81 | <input type="checkbox"/> Vitamin deficiency | 269.2 |
| <input type="checkbox"/> Celiac disease | 579.0 | <input type="checkbox"/> CKD, unspecified | 585.9 |
| <input type="checkbox"/> Hyperlipidemia | 272.2 | <input type="checkbox"/> Anorexia | 307.1 |
| <input type="checkbox"/> Bulimia | 307.51 | <input type="checkbox"/> Unspecified Nutrition Deficiency | 269.9 |
| <input type="checkbox"/> Other _____ | ICD-9 _____ | | |

Physician Signature _____ Date _____

License # _____