



www.Lighthouse-Nutrition.com

We currently accept Aetna, BCBS, Cigna, First Choice, Humana, Kaiser, Molina (21 and younger), Medicare (CKD/DM2), Premera and Regence.

LIGHTHOUSE NUTRITION & WELLNESS

Catherine Hains, MS, RDN, CLT, CD

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Thank you for your referral!

REFERRAL FOR OUTPATIENT NUTRITION SERVICES

Telehealth and in-person available

Clinic making the Referral: _____ Date: _____

Patient Name: _____ DOB: _____

Telephone: (H) _____ (W) _____ (Cell) _____

Address: _____ Email address: _____

Patient Insurance Policy Name: _____ ID: _____ Group # _____

Subscriber Name (if not the patient): _____ Subscriber DOB (if not the patient): _____

If you have them, PLEASE FAX the most recent and relevant clinical information, physician notes and labs (such as hemoglobin A1C, lipid profile, blood pressure, allergy panels)

LIPID/CARDIOVASCULAR

- E78.0, Hypercholesterolemia
- E78.1, Hypertriglyceridemia
- E78.5, Hyperlipidemia, unspec.
- I125.10, Cardiovascular Disease
- I10, Hypertension, unspecified

CLINICAL INFORMATION: Please check ALL applicable reasons for nutrition referral. Write in additional diagnoses with ICD-10 codes

DIABETES

- Diabetes, Type 2
- Hypoglycemia, unspecified

EATING DISORDERS

- F50.9, Eating disorder, unspecified

Other or additional diagnoses: _____

WEIGHT MANAGEMENT

- E 66.9 Obesity, unspecified
- E66.0 Obesity, morbid (BMI ≥40)
- E66.3, Overweight (BMI 25-29.9)
- R6251, Failure to thrive (child)
- R62.7, Failure to thrive (adult)

RENAL

- N18.1 CKD (Stage 1)
- N18.2 CKD (Stage 2)
- N18.3 CKD (Stage 3)
- N18.4 CKD (Stage 4)
- N18.9 ESRD requiring dialysis

GASTROINTESTINAL

- K50.90 Crohn's Disease
- K51.90 Ulcerative Colitis
- K90.0 Celiac Disease
- K57.90 Diverticulosis
- K57.92 Diverticulitis
- 474.60 Non-alcoholic Cirrhosis
- K76.9 Unspec. Chronic Liver Dz
- K21.9 Reflux/GERD
- K74.69 Cirrhosis-Nutritional
- K58.9 Irritable Bowel Syndrome
- K58.0 IBS w/Diarrhea
- E73.9 Lactose Intolerance
- E46 Malnutrition

Physician Information:

I have referred the above patient to Lighthouse Nutrition & Wellness for nutrition counseling for approximately _____ # of sessions.

Physician Name: _____ NPI#: _____ Address: _____

Phone: _____ Fax #: _____

Physician Signature (REQUIRED): _____ Date: _____

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