Referral Form - Laura H Smith Nutrition LLC

laurahsmithnutrition.com – Phone 512-359-8459

Please fax completed form with demographic and insurance information, pertinent medical history and labs to 512-582-2957.

Patient Name _____ DOB _____

Patient's Daytime Phone _____Reason for Referral_____

Insurance Name _____ Insurance ID Number _____

Referring Provider Signature/Printed Name _____

Office/Clinic Address _____

Office Phone _____Office Fax _____

Please provide date and results for applicable labs (or provide attachment):

HbA1c _____
Glucose _____
BUN _____
Creat _____

eGFR _____
AST/ALT _____
Other _____
Other _____

TChol _____
HDL _____
LDL _____
TG _____

ICD 10 Code required (please check all that apply or add applicable ICD 10 code):

- ☐ E11.9 Type 2 DM w/o complications
- ☐ E11.65 Type 2 DM w/ hyperglycemia
- ☐ E10.9 Type 1 DM
- ☐ O24._ Gestational DM
- ☐ R73.03 Prediabetes
- ☐ E66.3 Overweight
- ☐ E66.9 Obesity
- ☐ E88.81 Metabolic Syndrome
- ☐ E78.5 Hyperlipidemia
- ☐ I10 Essential Hypertension
- ☐ I50 Heart Failure
- ☐ Z93.1 Gastrostomy Status
- ☐ Z71.3 Dietary Counseling & Surveillance
- ☐ R63.4 Abnormal Weight Loss
- ☐ R63.6 Underweight
- ☐ N18.31 CKD, Stage 3a
- ☐ N18.32 CKD, Stage 3b
- ☐ N18.4 CKD, Stage 4
- ☐ N18.5 CKD, Stage 5
- ☐ N18.9 CKD, Unspecified
- ☐ Other: _____

Cleared to exercise?

- ☐ Yes
- ☐ No
- ☐ With Restrictions _____

Please indicate any special needs:

- ☐ Language/Interpreter
- ☐ Hearing
- ☐ Literacy
- ☐ Vision
- ☐ Cognitive
- ☐ Physical