Physician Referral Form

Please provide the information noted below regarding the patient you wish to refer for nutrition therapy. If this is being completed by physician staff, please fax a physician-signed referral note to 276-225-3555. Thank you for your referral!

Patient Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Referred by

Referral Needs

- ◯ New Diagnosis
- ◯ New Treatment Plan
- ◯ New Complication
- ◯ Other

If "Other", please specify

Special Needs

- ◯ Language
- ◯ Hearing/Speech/Vision
- ◯ Learning Processing
- ◯ Other

If "Other", please specify

ICD-10 Diagnosis

List all diagnoses that apply to this referral

ICD-10 Code/Description:	
ICD-10 Code/Description:	

Does patient plan to pay for Dietitian services through Medicare? ◯ Yes ◯ No

Health Insurance Information

Please attach copy of front and back of card. (If patient is primary insurance holder please leave as "myself.")

Policy Holder | First name | Last name

Date of birth | Gender | Phone number

Street | Unit

City | State/Province | Postal code

Insurance Company | Payer Id | Coverage Type

Member Id | Plan Id | Group Id

Copay | Deductible

Is patient released to discuss light physical activity?

For example, recommending 20 minutes of walking daily.

◯ Yes ◯ No

Physician Information

Title | First name | Last name

Work phone | Mobile phone | Fax number

Email address

Title/Occupation

Physician NPI

Additional information

Please fax any applicable information to 276-225-3555

- ☐ Current Medical Labs
- ☐ Current Medication List
- ☐ Most Recent Physician Note

Physician Signature

The information requested above is Protected Health Information (PHI) and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.

X

Print name: **Date:**