Person completing this form name and phone number ______________________ __________

Salem Health

Outpatient Nutrition Education Referral Form

PLEASE NOTE: This form is for Medical Nutrition Therapy (MNT) only. For accredited diabetes education with class options and for the gestational diabetes Sweet Moms program use the Salem Health Diabetes Education Referral form.

PATIENT INFORMATION

APPOINTMENT AT: ☐ **SALEM HOSPITAL** ☐ **WEST VALLEY HOSPITAL**

Last Name: __________ First Name: __________ MI: ____ Date of Birth: ____

Address: __________ Phone: __________ Language: __________

City: __________ State: __________ Zip Code: __________

PHYSICIAN ADMISSION DATA

Referring Provider: __________ Date of Referral: __________

Phone Number: __________ Fax Number: __________

Primary Care Physician: __________ Phone Number: __________

INSURANCE DATA

Insurance Company: __________ Subscriber Name: __________

Is insurance authorization require: ☐ yes ☐ no

Authorization #: __________ Approved for date rate of: __________

Policy Number: __________ Group Number: __________ Subscriber's Phone Number: __________

DIAGNOSIS/REASON FOR MEDICAL NUTRITION THERAPY: CHECK ALL THAT APPLY

- ☐ Abnormal weight loss
  Specify cause:
  - ☐ anorexia nervosa
  - ☐ bulimia nervosa
  - ☐ eating disorder NOS
  - ☐ cancer of: (*specify*: __________)
  - ☐ other: __________
- ☐ Anorexia Nervosa
- ☐ Bulimia Nervosa
- ☐ Eating disorder NOS
- ☐ CAD
- ☐ Cancer (specify: __________)
- ☐ Crohn's disease NOS
- ☐ Celiac disease/gluten intolerance
- ☐ Diabetes:
  - ☐ Type 1, controlled ☐ Type 1, uncontrolled
  - ☐ Type 2, controlled ☐ Type 2, uncontrolled
- ☐ Feeding problems
- ☐ FTT ☐ FTT newborn ☐ child ☐ adult
- ☐ Gastroparesis (*non-diabetes*)
- ☐ HTN NOS
  - ☐ benign ☐ malignant
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Hypertriglyceridemia
- ☐ IBS
- ☐ Liver disease: __________
  - ☐ NASH ☐ cirrhosis ☐ hepatitis
- ☐ Malabsorption NOS
- ☐ Malnutrition/PCM NOS
- ☐ Metabolic syndrome (*dysmetabolic syn x)*
  - ☐ Other specified disorder of metabolism
- ☐ Pre-diabetes/IGT:
  - ☐ impaired glucose tolerance
  - ☐ impaired glucose tolerance per GTT
  - ☐ other IGT (*specify*)
- ☐ Obesity
  - ☐ morbid obesity
- ☐ PCOS
- ☐ Renal insuciency NOS
  - ☐ or specific code
- ☐ Other diagnosis (*specify*) __________

  ____

■ **SUPPORTING DOCUMENTATION SUCH AS RECENT LABS, CHART NOTES, AND MEDICATION LIST MUST ACCOMPANY REFERRAL.**

COMMENTS OR SPECIAL INSTRUCTIONS: __________

____

Provider Signature: __________ Date: __________

Thank you for your referral! After receiving this form we will contact the patient to set up the appointment. Your office will be notified if we are unable to make contact with the patient or the patient refuses services.

DSC 432216 (1/18)