Salem Health

Outpatient Nutrition Education Referral Form

SALEM HEALTH
An OHSU Partner

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 HEALTH** ☐ **SALEM HEALTH WEST VALLEY**

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.

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