SAMPSON
REGIONAL MEDICAL CENTER

Outpatient Medical Nutrition Therapy Referral

Patient's Name: _____

Date of Birth/Gender: _____Daytime Phone Number: _____

Mailing Address: _____

_____

Ordering Provider/Address/Fax:_____

_____

Please confirm if ordering provider would like a full documentation of initial assessment and follow up appointments. ☐ **YES** ☐ **NO**

Medical Nutrition Therapy for:

☐ Gestational Diabetes (648.83)
☐ Pregnancy, complicated by pre-existing DM (648.00)
☐ Type 2 Diabetes, new onset (250.00)
☐ Type 2 Diabetes, uncontrolled (250.02)
☐ Type 1 Diabetes, new onset (250.01)
☐ Type 1 Diabetes, uncontrolled (250.03)
☐ Dysmetabolic Syndrome X (277.7)
☐ Obesity (278.00)
☐ Hyperlipidemia (272.4)
☐ Hypertension (401.9)
☐ Osteoporosis (733.00)
☐ Dysphagia (787.2)
Other: _____
Unspecified (585.9)

☐ Hypoglycemia, in absence of DM (251.2)
☐ Pediatric Failure to Thrive (783.41)
☐ Unplanned Weight Loss (783.21)
☐ Weight Loss/Pregnancy (646.83, 783.21)
☐ Malnutrition (263.9)
☐ Enteral Feeding Management (V65.3)
☐ Hyperemesis Gravidarum (643.03)
☐ Post Kidney Transplant (v42.0)
☐ Chronic Renal Failure - **Circle One**
* Stage I (585.1) * Stage II (585.2)
* Stage III (585.3) * Stage IV (585.4)
* Stage V (585.5) *ESRD (585.6)
*** Chronic Kidney Disorder**

Anthropometrics:

Height _____ Weight: _____

Relevant Lab Data:

$HgbA_1C$ _____ Blood Glucose_____

Total Cholesterol_____ LDL_____ HDL_____ Triglycerides_____

Relevant Medications: Please attach list of pertinent medications

Exercise Restriction:

☐None ☐Restricted to:_____

Please fax this form to SRMC Food and Nutrition Services at 910-590-2321

Dietitian will contact patient directly to schedule appointment.
For Questions, call 910-592-8511 ext. 8506