Treatment (Non-RD) Referral Form

Please call our office to schedule an appointment Appleton/Oshkosh (920) 364-9078 or DePere (920)570-6339. Form can be faxed by physician to our office (920) 243-1792.

TYPE OF TREATMENT REFERRING TO: ___Outpatient counseling __ IOP __ PHP

1. FROM:

Referring Provider Name: _____ Clinic: _____
Address: _____
Phone: _____ Fax: _____
Provider's Signature: _____

2. Patient Info:

Patient's Name: _____Parent/Guardian Name: _____
Phone number(s): _____

3. ICD 10 Diagnosis. Please circle or write in dx and ICD 10 code. If no dx code is noted, an assessment with a therapist will be scheduled prior to seeing a dietitian.

Anorexia Nervosa/Restricting: F50.01
Anorexia Nervosa/Binge/Purge: F50.02
Anorexia Nervosa/Unspecified: F50.00
Binge Eating Disorder: F50.81
Avoidant/Restrictive Food Intake Disorder (ARFID): F50.82
Bulimia Nervosa: F50.2
Unspecified Feeding or Eating Disorder: F50.9
OtherDiagnosis: _____
Unknown: _____

4. Please attach the following (if applicable):

- ✔ **Growth charts and records**
- ✔ **Standard labs:**
  - CBC with differential
  - UA
  - Complete Metabolic Profile
  - PO4, Serum Mg
  - Thyroid Screen (T3, T4, TSH)
  - EKG

5. Insurance information:

- Insurance carrier: _____
- Individual ID number: _____