Nutrition Referral Form

Please call our office to schedule an appointment (920) 364-9078. Form can be faxed by physician to our office (920) 243-1792.

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

Diagnosis: ____ ICD 10: _____________________

4. Please attach the following:

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

5. Please attach if wt loss 15% or more below IBW lasting 6 months or longer at any time during course of eating disorder:

- DEXA
- Estradiol Level (or Testosterone in males)
- Chest X-Ray

****Please note if client is in need of nutritional restoration, we will start supplementation of: Thiamine** 200mg QD for 10+ days; and **Zinc** 15mg lozenges QD for 2 months.**