

EVOLUTION

nutrition counseling by dietitians

Referral for Nutrition Counseling

Patient: _____ DOB: _____

Phone #: _____ Cell #: _____

Patient's Address: _____

Insurance Provider: _____

ID #: _____ Group #: _____

Please include the provider's most recent notes, patient's medication list, and blood work.

Please select all diagnoses and provide the most specific code possible.

- | | |
|---|--|
| <input type="checkbox"/> Abnormal weight loss (R63.4____) | <input type="checkbox"/> Food allergy (Z91.01____) |
| <input type="checkbox"/> Anemia (D64.____) | <input type="checkbox"/> Gastritis (K29.70) |
| <input type="checkbox"/> Anorexia nervosa (F50.____) | <input type="checkbox"/> Gastroesophageal reflux disease (K21.____) |
| <input type="checkbox"/> Barrett's esophagus (K22.7____) | <input type="checkbox"/> Gastroparesis (K31.84) |
| <input type="checkbox"/> Celiac disease (K90.0) | <input type="checkbox"/> Hyperlipidemia (E78. ____) |
| <input type="checkbox"/> Bulimia nervosa (F50.2) | <input type="checkbox"/> Hypertension (I10. ____) |
| <input type="checkbox"/> Change in bowel habit (R19.4____) | <input type="checkbox"/> Hypoglycemia (E16.2____) |
| <input type="checkbox"/> Constipation (K59.____) | <input type="checkbox"/> Hypothyroidism (E03.9____) |
| <input type="checkbox"/> Crohn's disease (K50.____) | <input type="checkbox"/> Impaired fasting glucose (R73. ____) |
| <input type="checkbox"/> Diabetes, type 1 (E10.____) | <input type="checkbox"/> Irritable bowel syndrome (K58.____) |
| <input type="checkbox"/> Diabetes, type 2 (E11.____) | <input type="checkbox"/> Lactose intolerance (E73.____) |
| <input type="checkbox"/> Diarrhea (K59.1____) | <input type="checkbox"/> Non-alcoholic fatty liver disease (K76.0) |
| <input type="checkbox"/> Diverticular disease (K57.____) | <input type="checkbox"/> Obesity/Overweight (E66.____) Ht: ____ Wt: ____ |
| <input type="checkbox"/> Dyspepsia (K30.____) | <input type="checkbox"/> Other eating disorder (F50.8) |
| <input type="checkbox"/> Family hx of cardiovascular disease (Z82.49) | <input type="checkbox"/> Other issues concerning food & fluid intake (R63.8) |
| <input type="checkbox"/> Family hx of diabetes (Z83.3) | <input type="checkbox"/> Ulcerative colitis (K51.____) |
| <input type="checkbox"/> Eating disorder (F50.____) | <input type="checkbox"/> Underweight (R63.6____) Ht: ____ Wt: ____ |
| <input type="checkbox"/> Eosinophilic esophagitis (K20.0) | <input type="checkbox"/> Vitamin D deficiency (E55.9) |
| <input type="checkbox"/> Failure to thrive, child (R62.51) | <input type="checkbox"/> Other: _____ (____) |

Notes:

Referred By: _____ Date: _____

Phone: _____ Practice or Facility: _____

Bristol ▪ East Greenwich ▪ East Providence ▪ Newport ▪ Pawtucket ▪ Providence
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