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.

- □ Abnormal weight loss or weight gain
- □ Anemia
- □ Anorexia nervosa
- □ Bulimia nervosa
- □ Celiac disease
- □ Change in bowel habit
- □ Constipation
- □ Crohn's disease
- □ Diabetes, type 1
- □ Diabetes, type 2
- □ Diarrhea
- □ Diverticular disease
- □ Dyspepsia
- □ Family hx of cardiovascular disease
- □ Family hx of diabetes
- □ Eating disorder
- □ Eosinophilic esophagitis (EOE)
- □ Failure to thrive (FTT), child
- □ FPIES
- □ Food allergy (specify: _______________)
- □ Gastritis
- □ Gastroesophageal reflux disease
- □ Gastroparesis
- □ Hyperlipidemia
- □ Hypertension
- □ Hypoglycemia
- □ Hypothyroidism
- □ Impaired fasting glucose
- □ Irritable bowel syndrome
- □ Lactose intolerance
- □ Non-alcoholic fatty liver disease
- □ Other issues concerning food & fluid intake
- □ Prediabetes
- □ PCOS
- □ Small intestinal bacterial overgrowth (SIBO)
- □ Ulcerative colitis
- □ Vitamin D deficiency
- □ Weight Concern
- □ Other:___________________________________

Notes:

Referred By: ____ **Date**: ________________

Phone: ______________________ **Practice or Facility**: ______________________________________

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