Medical Nutrition Therapy Referral Form

Durham County Department of Public Health

Please complete and fax to 919-560-7786 Questions, call 919-560-7791

PATIENT INFORMATION

Patient Full Name: ______________________ Date of Birth: ____/____/____

Gender: ☐ Male ☐ Female *Language*: ☐ English ☐ Spanish ☐ Other : ______________

Parent/Guardian Name: ______________________ Phone: ______________

Address: ____

Insurance: ☐ Medicaid ☐ Health Choice ☐ Private Insurance ☐ Uninsured

Policy Number: ____

Patient may be responsible for charges not covered by insurance. Fees are based on a sliding scale.

PARENT OR GUARDIAN TO COMPLETE

Parent/guardian concerns: ____

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Primary Care Physician: ______________________ Phone: ______________

Clinic Name: ______________________ Fax: ______________

I give consent for Durham County Department of Public Health to obtain doctor's orders for nutrition services from my child's physician.

Doy mi consentimiento para que el Depto. de Salud Publica consigue ordens para los servicios de nutricion del medico de mi hijo/hija.

Signature / *Firma* ______________________ Date / *Fecha* ______________

PHYSICIAN TO COMPLETE

☐ OVERWEIGHT or OBESE ☐ POOR APPETITE ☐ G TUBE

☐ UNDERWEIGHT ☐ FEEDING DIFFICULTIES ☐ FOOD ALLERGY

☐ FAILURE TO THRIVE ☐ CONSTIPATION ☐ OTHER: ______________

☐ PICKY EATING ☐ ELEVATED LEAD ______________

Diagnoses: ______________________ ICD-10 Code(s): ______________

Expected Nutrition Outcome: ____

Height/Length: ________ Weight: ________ BMI-for-age percentile: ________ Date: ________

Birth weight: ________ Gestational Age: ________ Exercise Restrictions: ______________

Physician Signature: ______________________ NPI #: ______________

Physician Name (please print): ______________________ Referral Date: ______________

Please attach whenever available: ☐ GROWTH CHARTS ☐ LAB RESULTS ☐ MEDICATIONS

Public Health

Durham County Department of Public Health
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