



Registered Dietitian Referral Form

FAX: 888-789-8394 or EMAIL: btownoffice2@newoutlookcc.org

Referring Provider Name: _____ Agency: _____

Referral Phone # and Email: _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name _____

Address (incl zip): _____

Home Phone#: _____ Cell Phone#: _____ SSN: _____

DOB: ___/___/___ Sex: _____ Race: _____ Marital Status: Single Married Divorced Widowed

Insurance Type: _____ Insurance ID#: _____ Group _____

Emergency Contact Name: _____ Relationship to Patient: _____ Contact #: _____

Primary Care Physician: _____ Phone #: _____

CLINICAL INFORMATION

Reason for Referral _____

Diagnosis (list confirmed if known, if not list suspected)

Primary Psychiatric Diagnosis: _____

Secondary Psychiatric Diagnoses (including substance abuse): _____

Any health conditions/diagnosis such as diabetes, hypertension, high cholesterol, etc _____

Any concerning behaviors, trauma, family issues around food and/or exercise _____

Relevant Social Factors: _____

Past Psychiatric History and Treatment (please check appropriately)

Former Therapy? No Yes Details _____

Hx of Psychiatric Hospitalizations? No Yes Details _____

Hx of Residential Treatment? No Yes Details _____

Previous symptoms and diagnoses: _____

Family hx of chronic mental health/medical diagnosis? _____

Current Psychiatric Treatment and History

Does patient have current outpatient mental health provider? No Yes Details _____

Additional Information: _____

Current Psychiatric Medications (name & dose, attach list if preferred) _____

Signature of Referral Source: _____ Date/Time _____