New Outlook Counseling Center

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

Registered Dietitian Referral Form

Referring Provider Name:_____ Agency:_____

Referral Phone # and Email:_____

----------PATIENT DEMOGRAPHIC INFORMATION----------

*Patient's Name: _____ *DOB: _____ Sex:_____

*Email Address: _____

Address (incl zip): _____

*Main Phone#: _____ Alt Phone#: _____ SSN:_____

*Insurance Type/Name: _____ *Insurance ID#: _____ Group#:_____

Insurance Carrier's Name: _____ DOB: _____ Relationship:_____

Emergency Contact: _____ Relationship _____ Contact #: _____

Primary Care Physician: _____ Phone #:_____

Current or Past Therapist: _____Contact Info: _____

----------CLINICAL INFORMATION----------

Reason for Referral-_____

_____

Previous Registered Dietitian Name_____ Contact#:_____

----------CURRENT MEDICAL INFOMATION----------

(Please Check all that Apply and Include ICD-10 code)

◇	Type 1 Diabetes	E10.___	◇	Hypertension	I10	◇	Hypertensive heart disease w/CHF	I11.0
◇	Type 2 Diabetes	E11.___	◇	Pre-diabetic	R73.03	◇	Abnormal weight loss	R63.4
◇	PCOS	E28.2	◇	GERD	K21.__	◇	Abnormal weight gain	R63.5
◇	Overweight/Obesity	E66.___	◇	Crohn's disease	K50.__	◇	Underweight	R63.6
◇	Mixed Hyperlipidemia	E78.2	◇	Ulcerative colitis	K51	◇	Eating disorder, unspecified	F50.9
◇	Anorexia Nervosa	F50.___	◇	Food Allergies	K52.2	◇	_____	
◇	Bulimia Nervosa	F50.2	◇	IBS	K58	◇	_____	
◇	Failure to thrive, child	R62.51	◇	Celiac disease	K90.0	◇	_____	

Current Medications- (Please include dose and frequency taken. Attach list if needed.)

_____

_____

_____

_____

Additional Info/Notes: _____

_____

Signature of Referral Source: _____ Date: _____