HealthEast®

OUTPATIENT NUTRITION REFERRAL FORM

To schedule an appointment with a Registered Dietitian, please call 651-232-5500.

Name: _____

_____
Address Phone #

Age_____ Height _____ Weight _____ Blood Pressure _____

RD to provide Nutritional Therapy for:
Referring Diagnosis:

- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Hyperlipidemia
- ☐ Metabolic Syndrome X
- ☐ Hypertension
- ☐ Malnutrition
- ☐ Celiac Sprue
- ☐ Congestive Heart Failure
- ☐ Tube-Feeding Management
- ☐ Pre-Dialysis Renal Failure
- ☐ Sleep Apnea
- ☐ Morbid Obesity
- ☐ Abnormal Weight Gain
- ☐ Other _____

Pertinent Lab Data (or attach report)

Glucose _____
Hg-A1C _____
Total Chol _____
LDL Chol _____
HDL Chol _____
Other _____

TG _____
Serum Albumin _____

For Chronic Kidney Disease Patients:

Serum creatinine _____ Calcium _____
GFR _____ Phosphorus _____
BUN _____ Potassium _____

Current Medications: _____
_____

Any Restrictions regarding exercise? _____

If none, please initial here for medical clearance for exercise _____

Nutritional counseling up to _____ **visits as medically necessary**

Physician/Provider Signature: _____ **Date:** _____ **Time:** _____

Printed Name: _____

Please fax referral form to HealthEast® Scheduling Services: fax number-651-326-8516

Please give the original form to the patient to deliver to the dietitian at the time of the scheduled appointment.
Please note: Reimbursement for dietitians' services is limited for Medicare patients. If you have other insurance, check with your insurance company to verify your insurance coverage.