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Nutrition Referral Form

Referring Provider Information (including name and NPI):

Patient Information:

Name: _____

Phone number: _____

Patient Information Continued:

Diagnosis (please check all that apply):

- ☐ Avoidant/restrictive food intake disorder (ARFID): F50.82
- ☐ Malnutrition/mild: E44.1
- ☐ Malnutrition/moderate: E44.0
- ☐ Abnormal Wt Loss: R63.4
- ☐ Gastroesophageal reflux disease with esophagitis: K21.0
- ☐ Gastroesophageal reflux disease without esophagitisK21.9
- ☐ Irritable Bowel Syndrome: K58.0
- ☐ Constipation: K59
- ☐ Functional diarrhea: K59.1
- ☐ Celiac Disease: K90.0
- ☐ Lactose intolerance, unspecified: E73.9
- ☐ Food Allergies: K52.2
- ☐ Functional Dyspepsia: K30
- ☐ Essential (primary) hypertension: I10
- ☐ Hyperlipidemia/Unspec: E78.5
- ☐ Pre-diabetes: R73.03
- ☐ Impaired Fasting Glucose: R73.01
- ☐ Metabolic syndrome: E88.81
- ☐ Other iron deficiency anemias (due to inadequate iron intake): D50.8
- ☐ Iron deficiency anemia, unspecified: D50.9
- ☐ Other dietary vitamin B12 deficiency anemia (vegan anemia): D51.3
- ☐ Dietary folate anemia: D52.0
- ☐ Protein deficiency anemia: D53.0
- ☐ Nutrition anemia, unspecified (simple chronic anemia) : D53.9
- ☐ Anemia, unspecified: D64.9
- ☐ Dietary counseling and surveillance: Z71.3

Diagnosis _____ ICD 10 _____

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*Please include any relevant labs, medications, or other information you would like me to have

Physician signature _____ Date _____