



**NUTRITION
SERVICE REQUISITION FORM**

Fax: 541-966-0504 Phone: 541-278-3235

NUTR

Patient Information

Patient Name: _____ DOB: _____ Male: Female:
Address: _____ City: _____ State: _____ Zip Code: _____
Parent/Guardian: _____ Phone/Contact #: _____

Insurance Information

Patient Insured: Yes No
Primary Insurance: _____ Group #: _____ Policy #: _____
Authorization Required: Yes No Authorization #: _____
Second Insurance: _____ Group #: _____ Policy #: _____
Authorization Required: Yes No Authorization #: _____

Physician Information

Ordering Physician Name: _____ Phone/Contact #: _____

Service Information

Patient Height: _____ Patient Weight: _____ BMI: _____

*****Please attach most recent lab values, medications and chart notes related to this referral.**

DIAGNOSIS (Check all that apply to this referral)

- | | | |
|---|--|--|
| <input type="checkbox"/> Morbid (severe) obesity due to excess calories | <input type="checkbox"/> Pure hypercholesterolemia | <input type="checkbox"/> Type 2 diabetes mellitus |
| <input type="checkbox"/> Obesity, unspecified | <input type="checkbox"/> Pure hyperglyceridemia | <input type="checkbox"/> Other abnormal fasting glucose (pre-diabetes) |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Mixed hyperlipidemia | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Underweight | <input type="checkbox"/> Essential hypertension | |
| <input type="checkbox"/> Abnormal weight loss | <input type="checkbox"/> Moderate protein-calorie malnutrition | |
| | <input type="checkbox"/> Unspecified severe protein calorie malnutrition | |
- ICD-10: _____

Authorized Signature

Ordering Physician Signature: _____ Date: _____

Referral valid from _____ to _____. If not specified, referral will be valid for 90 days.

Office Use

Patient Scheduled: _____ CPT Code: _____