CHI St. Anthony Hospital

NUTRITION

SERVICE REQUSITION 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)

- ☐ Morbid (severe) obesity due to excess calories
- ☐ Obesity, unspecified
- ☐ Overweight
- ☐ Underweight
- ☐ Abnormal weight loss

ICD-10: _____

- ☐ Pure hypercholesterolemia
- ☐ Pure hyperglyceridemia
- ☐ Mixed hyperlipidemia
- ☐ Essential hypertension
- ☐ Moderate protein-calorie malnutrition
- ☐ Unspecified severe protein calorie malnutrition

- ☐ Type 2 diabetes mellitus
- ☐ Other abnormal fasting glucose (pre-diabetes)
- ☐ Other: _____

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: _____