

Nutrition Evaluation and Counseling

Fax: 504.903.2023

Patient Label/Stamp

Referral from: BMC EKL LJC LAK
 LIH UMC WOM Other: _____

Attending Provider: _____ ID Number: _____

If Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ____/____/____

Date of Birth: ____/____/____ Medical Record Number: _____

1° Contact Number: _____ 2° Contact Number: _____

Email: _____

Diagnosis: Asthma Chronic Kidney Disease Coumadin
 Heart Failure Hemoglobinopathy Hyperlipidemia
 Hypertension Liver Disease History M I
 Wound Care Other _____

Diet Ordered: 2 Gram Sodium Low Fat/Cholesterol Calorie Restriction

Other: _____

Medications: _____

Services Offered:

Therapeutic Lifestyle Changes: A low fat/cholesterol, 2 gram sodium, high fiber diet with moderate physical activity. Kcal restriction may be recommended for weight loss as needed.

Lifestyle Balance Program: a 16 week, evidence-based program designed to help patients lose weight through healthy eating and physical activity.

Individual Appointments Available For: Food Allergies and intolerances, weight loss due to cancer, surgery and/or specific disease states, renal disease, at-home tube feeding, and upon request

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ ID Number: _____

Contact Number: _____ Referring Service/Clinic: _____

Fax Number: _____ Email: _____

OFFICE USE ONLY: Appointment Date: ____/____/____ Time: __:__ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

Rev 02/19/09