Pediatric ☐Parent/Guardian notified of referral ____________ Initial/Date

MEDICAL NUTRITION THERAPY REFERRAL
DURHAM COUNTY HEALTH DEPARTMENT

Fax or mail to Durham County Health Department, Nutrition Services, 414 East Main Street, Durham, NC 27701 ◆ 919/560-7791 fax 919/560-7786

For faxed referrals, original referral must follow by mail.

Patient____DOB_____/_____/_____
Name of parent/guardian_____________________________ Phone___________________
Gender: M F Language: ☐ English ☐ Spanish ☐ Other,_________________________
Address____
Directions to home (*when applicable*)____
____
Reimbursement Source: (*check all that apply*) ☐ Medicaid ☐ Health Choice ☐ Private Insurance
☐ Uninsured. Policy No:____
Patient may be responsible for charges not covered by insurance. Fees are based on a sliding scale.

Referral Information: *Completed by person making referral; please include all applicable information. Referral for nutrition counseling for medical conditions such as diabetes, hypertension, etc. must be completed by treating provider.* ***Information marked with an asterisk (*) must be completed.***

*Reason for Referral____
*Diagnoses____
*ICD-9 code(s)______________________________ ***Indicate ICD code to highest level of specificity***
*Nutrition Order: ☐ dietitian to evaluate & formulate ☐ other, *specify*____________________
____
Expected nutrition outcome____
Medications____
Relevant labs/other data____(date/s)
Height/length__________Weight_______________ (date)_________________________
BMI-for-age percentile_________Birth weight____________Gestational age:____________
Please include copies of growth charts when applicable.
Exercise restrictions____no ____yes, *specify*____________________________________
Referral Date__________ Provider completing referral/phone_____________________
*Patient's Physician (*signature*)____
Physician name (*please print*)______________________________UPIN #____________
Address___________________________Phone_______________Fax_____________

Additional Information:

For Nutrition Office Use Only

1.☐**Letter** Sent __________ 2.☐**1st TC** Made __________
3.☐**PC** Sent__________ 4.☐ **2ND TC** Made __________
5.____________________ 6. ____________________

Appointment(s).

1. Appointment Date______________ ☐**DNKA**----☐*Reschedule* ☐*Re-evaluate* ☐____________
2. Appointment Date______________ ☐**DNKA**----☐*Reschedule* ☐*Re-evaluate* ☐____________

NOTES:

DCHD#____________

Rev:9/2/2008