Telehealth Referral Form for Nutrition Consult

Referral Clinic Name:_____

Phone #_____ **Fax #**_____

Diagnosis:_____**ICD10 code**_____

Referring Provider:_____**Signature:**_____

Patient Information

Name: First _____ **MI**_____ **Last**_____

Date of birth: _____ **Male [ ] Female [ ]**

Patient address_____

City_____ **State**_____ **Zip**_____

Phone:_____ **Preferred language**_____

Email:_____

Insurance provider:_____**ID#**_____

Please provide the following prior to nutrition counseling:

____ current laboratory results _____mark here only if there are none available

____ copy of patient's demographic sheet

____ copy of physician notes describing recent treatments and/or history

____ copy of medication list

____ copy of client signed consent to treat form (this form must be faxed prior to consult with the patient)

____copy of valid TN photo ID or other ID

____ copy of insurance card front and back

Who the dietitian should send her notes to:

Secure fax_____ **Secure email:**_____

Address:_____

PLEASE FAX FORM TO DIETITIAN ASSOCIATES (901) 759-7967

Phone: (901) 759-9337