Nutrition Services
by **DIETITIAN ASSOCIATES**

# Telehealth Referral Form

**Referring Clinic:** ______________________________

Phone: ______________________ Fax: ______________________

Diagnosis: ______________________ ICD10 Code: __________

Referring Provider: ______________________ Signature: ______________________

## Patient Information

Name: ______________________ (FIRST / MI / LAST) Date of Birth: ___/___/___ ☐ Male ☐ Female

**Race:** ◯ American Indian ◯ Asian ◯ Black ◯ White ◯ Pacific Islander **Ethnicity:** ◯ Hispanic or Latino ◯ Non-Hispanic or Latino ◯ No data available

Address: ______________________________

City: ______________________ State: ________ Zip: ______________

Phone: ______________ Email: ______________________ Pref. Language: ______________

**Insurance Provider:** ______________________ **ID#:** ______________

### *Please provide the following prior to nutrition counseling:*

- ☐ Current labratory results
- ☐ 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 back prior to consult with the patient)
- ☐ Copy of valid Tennessee driver's license, photo ID or other ID
- ☐ Copy of insurance card front and back

**Who should Dietitian Associates send notes to:**

Secure Fax: ______________________ Secure Email: ______________________

Address: ______________________________

**PLEASE FAX FORM TO DIETITIAN ASSOCIATES:**
**(901) 759-7967**
**PHONE: (901) 759-9337**