

# Dietitian Referral Form



Fax to: 503-210-1729

Date: \_\_\_\_\_

**Patient Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Diagnosis (Please check all that apply):

<input type="checkbox"/> Allergy Food	Z91.01	<input type="checkbox"/> Hypertension	I10
<input type="checkbox"/> Anorexia/Bulimia Nervosa	R63.0	<input type="checkbox"/> Hypoglycemia	E16.2
<input type="checkbox"/> Cancer (specify type)		<input type="checkbox"/> Irritable Bowel Syndrome	K58
<input type="checkbox"/> Food Intolerance	K90.4	<input type="checkbox"/> Iron Deficiency Anemia	D50.9
<input type="checkbox"/> Diabetes Type 1 or Type 2	E10 E11	<input type="checkbox"/> Obesity	E66
<input type="checkbox"/> Fibromyalgia	M79.7	<input type="checkbox"/> PCOS	E28.2
<input type="checkbox"/> GERD	K21.9	<input type="checkbox"/> Renal Insufficiency	N18.9
<input type="checkbox"/> Hyperlipidemia	E78.5	<input type="checkbox"/> Other	

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

**Health Care Provider Name:** \_\_\_\_\_

Phone: \_\_\_\_\_