Dietitian Referral Form

Eating is a Lifestyle

Fax to: 503-210-1729

Date:_____

Patient Information:

Name:_____ Phone:_____

Date of Birth:_____ Email:_____

Diagnosis (Please check all that apply):

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

Additional Comments:_____

_____

Health Care Provider Name:_____

Phone:_____