Adult

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____/____/____
Gender: M F Language: ☐ English ☐ Spanish ☐ Other, ____________________
Address____Phone__________________
Reimbursement Source: (*check all that apply*) ☐ Medicaid ☐ Medicare, Part B ☐ 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.*

Reason for Referral____
Diagnoses______________________________**ICD-9 code(s)**________________
Indicate ICD code to highest level of specificity
Relevant labs/other data____(date/s)
Height/length__________Weight____________ (date)____________EDC__________
Medications____
Nutrition Order:____dietitian to evaluate & formulate ____other, *specify*__________________
____
Expected nutrition outcome____
Exercise restrictions___no ____yes, *specify*____________________________________
Referral Date__________ Provider completing referral/phone_______________________
Patient's Physician (*signature*)____
Physician name (*please print*)____________________________**UPIN #**____________
Address__________________________Phone______________Fax____________

For Medicare Part B diabetic and renal referrals: Referrals must be signed by treating physician. Please make sure above information in bold is completed and also include the additional information below:

No. of authorized visits____
Labs as applicable:
Fasting blood sugar__________________________ (date)___________________
Glomerular filtration rate______________________(date)___________________

For Nutrition Office Use Only

1. ☐ **Letter** Sent ____________________ 2. ☐ 1 st 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.8/08