NUTRITION CLINIC
OF NORTHERN CALIFORNIA
Food & Nutrition Experts

NUTRITIONAL REFERRAL FORM

www.nutritionworks4all.com

PATIENT INFORMATION	
Full Name:	
Date of Birth:	**SS#:**
Phone (Home):	**Phone (Cell):**

DIAGNOSIS FOR NUTRITION THERAPY (ICD-9 code is required for referral)

☐ 250.00 Diabetes Type 2	☐ 401.1 Hypertension (benign)	☐ 585.3 CKD, stage III (moderate)
☐ 250.01 Diabetes Type 1	☐ 428.0 CHF	☐ 585.4 CKD, stage IV, (severe)
☐ 250.02 Diabetes Type 2, uncontrolled	☐ 530.8 GERD	☐ 585.5 CKD, stage V
☐ 250.03 Diabetes Type 1, uncontrolled	☐ 555.1 Crohn's Disease	☐ 585.9 CKD, unspecified
☐ 256.4 Polycstic Ovaries	☐ 556 Ulcerative Colitis	☐ 783.1 Abnormal Weight Gain
☐ 272.2 Hyperlipidemia	☐ 564.1 IBS	☐ 783.2 Abnormal Weight Loss
☐ 278.00 Obesity	☐ 577.1 Chronic Pancreatitis	☐ 790.29 Pre-Diabetes / Hyperglycemia NOS
☐ 278.01 Morbid Obesity	☐ 579.0 Celiac Disease	☐ 042 HIV / AIDS
☐ 278.02 Overweight	☐	
☐ Other _____ (include ICD-9)		

SPECIFIC SERVICE REQUESTED (Required)

Goals of Nutrition Therapy:

☐ Weight Loss ☐ Lipid Management ☐ HTN Management

☐ Weight Gain ☐ DM Management

☐ Other _____

List specific diet order, if applicable: _____

Exercise Restrictions? ☐ Yes ☐ No Specify: _____

Physician Comments:

REFERRING PHYSICIAN	
Physician Name:	**Referral Date:**
Phone:	**Fax:**
Appointment Date:	**Physician's Signature:**

THANK YOU FOR YOUR REFERRAL