Pediatric Outpatient Nutrition Referral

Complete, Sign, and Fax to (512) 406-6520

Have the parent/guardian call (512) 324-0137 to schedule an appointment.

Patient Name: ________________________________ Preferred language: _______________________

Parent/Guardian Name: _________________________ Parent/Guardian/ Phone #: ____________________

Patient's Home Address: (street, city, zip)____

Insurance:______________________________ Policy# ________________________________

Referring Physician Name: ____

Referring Physician Office Phone: ___________________ Referring Physician Fax: _____________________

Primary Care Physician Name:____

Patient info: Age: _______ DOB: _______________ Sex: M F (circle one)

Date of measurements: __________________

(Please circle the unit.) Height: ________ (cm or in) Weight: _______ (kg or lb) BMI (kg/m^2): ________

Medications:____

Important information: ***BMI (Body Mass Index pediatric greater than or equal to 95th percentile for age), ICD-10 code 68.5 is not an acceptable nutritional diagnosis code, all referrals with this diagnosis will be rejected.***

REQUIRED: We require our specific Pediatric Outpatient Nutrition Referral Form to be FULLY completed or referral will be rejected. All referrals are required to have last clinical notes regarding diagnosis attached with referral. Please attach growth charts and/or Lab Work if available.

Diagnosis/Reason For Referral:
(please check all that apply)

- ☐ Eating Disorder (Please check one) ☐ Anorexia ☐ Bulimia
- ☐ Pre-diabetes
- ☐ Picky Eating
- ☐ Oral Aversion
- ☐ High blood Pressure
- ☐ Food Allergies
- ☐ Abnormal Menstrual
- ☐ Failure to Thrive (no Oral Aversion present)
- ☐ Abnormal Weight Gain
- ☐ Acanthosis Nigricans
- ☐ Lipid Abnormalities
- ☐ Tube Feeding Management (require current feeding plan)

_____________________________________ _____________

Referring Physician (signed) Date