ValleyHealth

Healthier, together.

Valley Health Wellness Services Outpatient Nutrition Referral Form

401 Campus Boulevard, Winchester, Virginia 22601

Our staff will contact to schedule appointments or patients may reach the office directly by calling 540-536-3050

To schedule an appointment, please **FAX** the following:

1. Completed referral form

2. Relevant clinical information to include H&P, labs, recent office note(s) and medications

Fax: 540-536-3045

Patient Information:

Patient Name: _____ DOB:_____

Address: _____

Patient Telephone:_____

Patient Insurance Coverage:_____

*please send copy of front and back of patient's insurance card

Clinical Data:

MedicalHistory:_____

_____

_____

Relevant Labs:_____

Exercise Plan/Activity: ☐Released ☐Released with restriction(comment below) ☐Not Released

Other comments/Information: _____

_____

Medical Diagnosis: Please select and/or write **ALL** applicable diagnosis.

☐E66.9-Obesity, unspecified
☐E66.3-Overweight
☐R63.5-Abnormal weight gain
☐Z68.54-BMI,pediatric,greater than or equal to 95th percentile
☐R63.4-Abnormal weight loss
☐R63.6-Underweight
☐Z68.51-BMI, pediatric, less than 5th percentile for age
☐Z72.4-Inappropriate diet&eating habits
☐Other:_____

☐I50-Heart failure
☐I10-Essential (primary) hypertension
☐E78.2-Mixed hyperlipidemia
☐E78.5-Hyperlipidemia, unspecified
☐N18.9-Chronic kidney disease, unspecified
☐N20.0-Calculus of kidney
☐K21.0-Gastroesophageal reflux disease with esophagitis
☐K31.84-Gastroparesis
☐Other:_____

☐K76-Fatty (change of) liver, not elsewhere classified
☐K90.0-Celiac disease
☐F50.0-Anorexia nervosa, unspecified
☐F50.2-Bulimia nervosa
☐F50.9-Eating disorder, unspecified
☐E43-Unspecified severe protein-calorie malnutrition
☐E46-Unspecified protein-calorie malnutrition
☐ Other:_____

Provider Information: I have referred the above patient to Valley Health Wellness Services for Medical Nutrition Therapy for the medical diagnoses checked above.

Physician Signature:_____ Date:_____

Physician Name (Print):_____

Office Phone:_____ Fax:_____

Office Address:_____