

**My Diabetes Dietitian**  
JUDY FISCHER  
RD-LDN-CDE  
\*Servicing Children and Adults\*

Office Location  
119-S Trade Street  
Suite 107  
Matthews, NC 28105

OUTPATIENT NUTRITION CLINIC  
**REFERRAL FORM**

Phone 704-846-7501  
Fax 704-973-7732

-----PATIENT INFORMATION-----

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Insurance \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

-----MEDICAL INFORMATION-----

Diagnosis: \_\_\_\_\_ ICD-9 DX Code \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_  
Medical History/Complications: \_\_\_\_\_  
Medications: \_\_\_\_\_

<u>Laboratory Data</u>	<u>Date</u>	<u>Result</u>
Fasting Glucose	_____	_____
HbA1C	_____	_____
Triglycerides	_____	_____
Cholesterol	_____	_____
LDL	_____	_____
HDL	_____	_____

-----MEDICAL NUTRITION THERAPY PLAN-----

Current Diet Therapy: None or: \_\_\_\_\_  
Physician's Goals for Patient: \_\_\_\_\_  
Physical Activity Limitations: None or: \_\_\_\_\_  
\* If None, Initial for Medical Clearance for Exercise \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
UPIN # \_\_\_\_\_  
NPI: # \_\_\_\_\_

\*\*\*THIS FORM MUST BE COMPLETED IN ENTIRETY BEFORE PATIENT CAN BE SCHEDULED\*\*\*\*\*