

JUDY FISCHER
RD-LDN-CDE
&
Associates

Matthews, NC 28105

My Diabetes Dietitian, Inc
OUTPATIENT NUTRITION CLINIC

REFERRAL FORM
Medical Nutrition Therapy for Adults and Children

Phone 704-846-7105
Fax 704-973-7732
Email:
MddStaff@carolina.rr.com

Website:
www.MDDHelp.com

-----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**