UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

UCSF Medical Center

UCSF Nutrition Counseling Clinic
Phone: (415) 353-2291 Fax: (415) 353-2648

NUTRITIONAL REFERRAL FORM

(To be completed by referring physician)

Referring Physician	Patient
Please put completed referral in Nutrition Mailbox at GMB, 4th Floor, 400 Parnassus. ***Or*** FAX referral to Nutrition Counseling Clinic: (415) 353-2648. If outside UCSF Medical Center, include relevant lab results. **Note: ICD-9 code is required on all nutrition referrals** **Please note: If patient is insured by Brown & Toland, enter referral in BTC.A.R.E. in lieu of written referral.**	1. Contact your insurance to determine coverage for nutrition counseling. If necessary, obtain preauthorization for your visit. 2. Call (415) 353-4174 to schedule your nutrition appointment. 3. **Bring this referral, signed by your MD, to your appointment or ask MD to send it directly to the Nutrition Counseling Clinic.** **Note: If you have Brown & Toland insurance, you do not need this written referral form.**

Diagnosis for Nutrition Therapy *(ICD-9 code is required for referral)*

- ☐ 250.00 Type 2 DM
- ☐ 250.01 Type 1 DM
- ☐ 250.02 Type 2 DM, uncontrolled
- ☐ 250.03 Type 1 DM, uncontrolled
- ☐ 256.4 Polycystic Ovaries
- ☐ 272.2 Hyperlipidemia, mixed
- ☐ 278.00 Obesity
- ☐ 278.01 Morbid Obesity
- ☐ 278.02 Overweight
- ☐ Other_____ (include ICD-9 code)
- ☐ 401.1 HTN, essential
- ☐ 428.0 CHF
- ☐ 530.81 GERD
- ☐ 555.1 Crohn's Dz
- ☐ 556 Ulcerative Colitis
- ☐ 564.1 IBS
- ☐ 577.1 Chronic Pancreatitis
- ☐ 579.0 Celiac Dz
- ☐ 585.3 CKD, stage III (moderate)
- ☐ 585.4 CKD, stage IV (severe)
- ☐ 585.5 CKD, stage V
- ☐ 585.9 CKD, unspecified
- ☐ 783.2 Abnormal Weight Loss
- ☐ 790.29 Pre-diabetes/hyperglycemia NOS
- ☐ 042 HIV/AIDS

Specific Service Requested (Required)

Goals of nutrition therapy

- ☐ Weight loss
- ☐ Weight gain
- ☐ HTN management
- ☐ Lipid management
- ☐ DM management
- ☐ Other _____

List specific diet order, if applicable: _____

Exercise Restrictions? ☐ yes ☐ no Specify: _____

Physician Comments:

Referring MD (print)_____ (sign)_____Provider #_____

Attending MD (print)_____ (sign)_____ Provider # _____

Clinic or Practice_____ Phone_____Date of referral_____

This referral is valid for 180 days from date of referring MD's signature.

802-004 (Rev. 12/09) WorkflowOne MEDICAL RECORD COPY