

Nutrition Referral
Craven County Health Department
Attn: Registered Dietitian: Lisa Mayo, RD, LDN
Office: 252-636-4920 Ext. 2077 Fax: 252-636-4980

PATIENT INFORMATION

Date: _____	
Patient Name: _____	DOB: _____ Sex: M F
Patient Address: _____	
Phone #: _____	Parent/Guardian: _____
Insurance/Phone # _____	Policy #: _____
Referring Office: _____	Medical Provider: _____
Contact Person: _____	Office Phone: _____
Office Fax: _____	Interpreter Needed: ___yes ___no

MNT REFERRAL INFORMATION

Ht: _____ Wt: _____
Reason for Nutrition Referral (Mark all that apply)
<input type="checkbox"/> Overweight
<input type="checkbox"/> Underweight
<input type="checkbox"/> Anemia (Hgb/Hct _____)
<input type="checkbox"/> HTN (BP _____)
<input type="checkbox"/> High Cholesterol (TC _____ LDL _____ HDL _____ TG _____)
<input type="checkbox"/> Diabetes (BS _____ HgA1C _____)
<input type="checkbox"/> Feeding Concerns (Infant/Child)
<input type="checkbox"/> Failure To Thrive
<input type="checkbox"/> Allergies/Intolerances
<input type="checkbox"/> Diet Concerns/Questions
<input type="checkbox"/> Other (specify) _____

Medical Diagnosis _____
ICD9 code(s): _____
MD signature: _____
NPI # _____
Duration of Consult _____

Relevant Labs/Other Data:

Medications:

Special Instructions/Comments: _____ _____ _____ _____ _____ _____
