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**NEW APPOINTMENT REFERRAL FORM**

**Outpatient Dietitian Referral**

* Please fax completed form to our central scheduling office at 402-955-6445
* Please send a copy of the front and back of the insurance card with this completed form
* Please send all relevant clinical documents (clinic notes, medication history, growth charts, labs, diagnostic reports, etc) related to this referral with this completed form
* **IF YOUR PATIENT NEEDS TO BE SEEN WITHIN 24 HOURS, PLEASE CALL 402-955-3838; Option 1**

For priority referrals, please indicate urgency below:

 Urgent (within 1 week)  Routine (next available appointment)



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| --- | --- | --- |
| Patient Last Name: | First: | Middle: |
| Date of Birth: | Sex: Male Female  |
| Address: City: State: Zip Code: |
| Parent(s)/Legal Guardian(s) Name: |
| Parent(s)/Legal Guardian(s) Phone Number(s): ( ) ( ) ( )  |
| Email: | Insurance Plan: |
| Interpreter Needed: Yes Language: | Primary Care Physician Name: |

**REFERRING PHYSICIAN INFORMATION**

|  |  |
| --- | --- |
| Referring Provider Name: |  Primary Care Provider  Other: |
| Provider NPI#:  | Practice Address: |
| Fax Number: | Phone Number: |

**APPOINTMENT REQUEST**

|  |  |
| --- | --- |
| Reason for Visit:  New Patient  Follow Up | Specialty: **Outpatient Nutrition Referral**  |
| Reason for Referral:[ ]  **High BMI/Wt Management** [ ]  **Underweight/Slow Weight Gain** [ ]  **Celiac Gluten Free Education** [ ]  **NICU Discharge Follow-Up** [ ]  **Food Allergies** [ ]  **Formula Mixing Validation & Instruction** [ ]  **Normal Infant/Toddler Nutrition-Progression** [ ]  **FODMAP Education** [ ]  **Sports Nutrition** [ ]  **Pre-Op Nutrition Assessment** [ ]  **Vegan/Vegetarian**  |
| PMH/Diagnosis:  |
| Additional Instructions: Please attach the patient’s growth chart and recent office visit  |