

# Active Wellness Center Nutrition Services Referral Form

Patient's First and Last Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

**THE ABOVE PATIENT IS TO RECEIVE MEDICAL NUTRITION THERAPY FOR THE FOLLOWING:**

- General Nutrition Education
- Weight Management
- New Diagnosis
- New Treatment Plan
- Other: \_\_\_\_\_

**PLEASE CHECK ALL RELEVANT DIAGNOSES & LIST ANY ADDITIONAL DIAGNOSES:**

ICD-10	ICD-10 DESCRIPTION	ICD-10	ICD-10 DESCRIPTION
<input type="checkbox"/> Z71.3	Dietary Counseling & surveillance	<input type="checkbox"/> D64.9	Anemia, unspecified
<input type="checkbox"/> E10.9	Type 1 DM without complications	<input type="checkbox"/> M81.0	Age-related osteoporosis
<input type="checkbox"/> E11.9	Type 2 DM without complications	<input type="checkbox"/> R73.03	Pre-diabetes
<input type="checkbox"/> E66.3	Overweight	<input type="checkbox"/> N18.1	CKD stage 1
<input type="checkbox"/> E66.9	Obesity, unspecified	<input type="checkbox"/> N18.2	CKD stage 2
<input type="checkbox"/> R63.6	Underweight	<input type="checkbox"/> N18.3	CKD stage 3
<input type="checkbox"/> I10	Primary Hypertension	<input type="checkbox"/> N18.4	CKD stage 4
<input type="checkbox"/> K50.9	Chron's disease, unspecified	<input type="checkbox"/> N18.5	CKD stage 5
<input type="checkbox"/> K51	Ulcerative Colitis	<input type="checkbox"/> -----	-----
<input type="checkbox"/> K58	Irritable Bowel Syndrome	<input type="checkbox"/> -----	-----
<input type="checkbox"/> K90.0	Celiac Disease	<input type="checkbox"/> -----	-----
<input type="checkbox"/> E03.9	Hypothyroidism, unspecified	<input type="checkbox"/> -----	-----

**LAB WORK:** Attach or fax most recent & relevant lab work.

**INSURANCE:** Attach a copy of front and back of card.

**ACTIVITY RESTRICTION:** If none, list N/A

Physician's Printed Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

**CURRENT MEDICATIONS:** List below or attach list.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

NPI: \_\_\_\_\_

Date: \_\_\_\_\_

**Fax completed form to patient's Active Wellness Center location and provide copy to patient.**

<b>NAPA</b> 3421 Villa Lane Napa, CA 94558 Fax: 707.251.1373	<b>PETALUMA</b> 1201 Redwood Way, Petaluma, CA 94954 Fax: 707.789.7028
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For more info, please contact our Registered Dietitian directly at **707.257.4013** or **isabel.debnam@activewellnesscenter.com**.

