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Another brand of drug identical in form and content may be dispensed unless checked

Date: _____

OUTPATIENT NUTRITION REFERRAL FORM

To schedule an appointment with a Registered Dietitian, please call 256-429-4888

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____ Gender: Female Male

Address: _____

Phone Number (Best Contact): _____ (Other) _____

Email: _____

Height: _____ Weight: _____ Date Weight Last Taken: _____

INSURANCE:

Health Insurance: _____

Policy Holder: _____ Group Number: _____

ID Member Number: _____

** Patient understands medical nutrition therapy is self-pay and accepts responsibility for payment of services not covered by insurance? ** Yes No

RD TO PROVIDE NUTRITION SERVICES FOR:

Referring Reason/Diagnosis: _____

Has this patient been tested for COVID-19 in the last 30 days? Yes No

Has this patient shown any s/s of COVID-19 in the last 30 days? Yes No

If answering YES to either of these questions – please call the department at 256-429-4943.

Physician Comments: _____

Please attach copies of the following: H&P, Medication List, and Current Labs Data

Referring MD (Print): _____

Phone: _____ Fax: _____

Clinic or Practice: _____

Please Fax Referral Form to Crestwood Central Scheduling 256-429-4612.

Physician Signature _____

Date _____

Time _____