NUTRIT

SOUTHCOAST HOSPITALS GROUP

DO NOT WRITE IN THIS SPACE
Affix Patient Label Here

Outpatient Nutrition Counseling Request Form – SHG

Referral may be entered in EPIC by Southcoast providers or
Please call **or** fax Centralized Scheduling to schedule an appointment.
Centralized Scheduling Phone: (508) 973-3900 or (800) 276-0103
Fax: (508)973-3905
Please fax order directly to the site ONLY if the appointment has been scheduled

PLEASE CHECK SITE: ☐ St. Luke's Hospital – 101 Page Street, New Bedford, MA. Fax # 508-973-5166
☐ Tobey Hospital – 43 High Street, Wareham, MA. Fax # 508-973-5166
☐ Hanover Building – 235 Hanover Street, Fall River, MA Fax # 508-973-5166
☐ Other _____ Fax # 508-973-5166

APPT. DATE: _____ APPT. TIME: _____

PT. NAME: _____

ADDRESS: _____

PHONE: _____ MED REC #: _____ DOB: _____

ORDERING PHYSICIAN: _____PHONE #: _____

PRIMARY CARE PHYSICIAN: _____

Please check all diagnosis that apply: (column 1 are Medicare approved diagnoses)

	Type 1 Diabetes Mellitus without Complication	E10.9		Obesity	E66.9		Celiac Disease	K90.0
	Type 1 Diabetes Mellitus with other specified complication	E10.69		Overweight Body mass index 25-29.9 kg/(m^2)	E66.3		Anorexia Nervosa	F50.0
	Type 2 Diabetes Mellitus without Complication	E11.9		Hypercholesterolemia	E78.0-E78.7		Bulimia Nervosa	F50.2
	Type 2 Diabetes Mellitus with other specified complication	E11.69		Abnormal weight loss	R63.4		Other Eating Disorder	F50.8
	Chronic Kidney Disease, stage 3 (moderate)	N18.3		Irritable Bowel Syndrome – Constipation	K58.1		Malnutrition, Unspecified	E46.0
	Chronic Kidney Disease, stage 4 (severe)	N18.4		Irritable Bowel Syndrome – Diarrhea	K58.0		Failure to Thrive (child)	R62.51
	Chronic Kidney disease, stage 5 (severe)	N18.5		Irritable Bowel Syndrome - Mixed	K58.2		Diverticulitis of the Colon (without perforation or abscess)	K57.32

Other diagnosis codes to include:_____

PLEASE FAX PERTINENT LABS/DATA:
☐ For **diabetes** please include HGBA1C, fasting blood glucose, lipids
☐ For **cardiac** please include lipid panel, blood pressure
☐ For **pediatrics** please include growth charts, available lab results
☐ For **malnutrition** please include CBC, available lab results, weight history
☐ For **gastrointestinal diseases** please include results of diagnostic testing

OTHER COMMENTS:

_____

_____

PROVIDER SIGNATURE:_____ Date: _____ Time: _____

PCC / APPROVAL / REFERRAL #: _____