# Nutrition Referral Form

***Please ask the patient to call my office to schedule an appointment: (**615) 492-1444
***Please Securely Fax Completed form to:** 1 (800) 378-7034

From: Physician's Signature: _____
Patient's Name: _____
Phone number(s): _____

**ICD 10 Diagnosis (please circle any that apply, write in additional below)**

Abnormal Wt Gain: R63.5 Amenorrhea: N91.2 Anorexia Nervosa/Restricting: F50.01

Anorexia Nervosa/Unspecified: F50.00 Bulimia Nervosa: F50. Eating Disorder NOS: F50.9

Avoidant/restrictive food intake disorder (ARFID): F50.89 Binge Eating Disorder: F50.82

Celiac Disease: K90.0 Diabetes type 1 w/out complications: E10.9 Malnutrition/mild: E44.1

Diabetes type 2 w/ hyperglycemia: E11.65 Diabetes type 2 w/out complications: E11.9

Failure to Thrive/Adult: R62.7 Failure to Thrive/Child: R62.51 Food Allergies: K52.2

Gestational DM/diet controlled: O24.410 Overweight: E66. Obesity/NOS: E66.93

Hypercholesterolemia/Pure: E78.00 Hyperlipidemia/Un: E78.5 Malnutrition/moderate: E44.0

HyperTG/Pure: E78.1 Irritable Bowel Syndrome: K58.0 HTN/Essential/Primary: I10

**Diagnosis: _____ ICD 10: _____**
**Diagnosis: _____ ICD 10: _____**
**Diagnosis: _____ ICD 10: _____**

***** Please attach Labs, Growth and/or BMI Charts, or any other information you wish for me to have*****