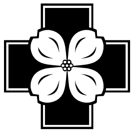

ST. JOSEPH
Regional Medical Center

415 6th Street
Lewiston, Idaho 83501

Outpatient Nutrition Services
Physician Referral/Order
Phone: (208) 799-5558

FAX COMPLETED FORM TO: (208) 799-5583

Patient Name:____ DOB:____/____/____
Contact Phone ( )__________________________ Work Phone ( )__________________________
Insurance type:__________________________ Referring care provider:__________________________

1. (REQUIRED as available)
Labs: FBS ____________________ Date:_____________
(or 2 hr GTT) ____________ Date:_____________
Hgb A1C________________ Date:_____________
Potassium (K+): __________ Date:_____________
Albumin: _______________ Date:_____________
Medications: (Okay to attach to sheet) ____

Lipid Profile (if available):
HDL ______________________ Date:_____________
LDL_______________________ Date:_____________
Cholesterol ________________ Date:_____________
Triglycerides _______________ Date:_____________

2. Diagnosis: (please check appropriate diagnosis)
- ☐ Weight gain
- ☐ Weight loss
- ☐ Obesity
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Pre-diabetes
- ☐ Metabolic Syndrome
- ☐ Cardiovascular disease/arteriosclerosis
- ☐ Other:____

Instruct Patient as follows: ____

Medical Nutrition Therapy for Diabetes or Renal Disease
(please check appropriate diagnosis)
- ☐ Type 1 DM, new diagnosis
- ☐ Type 1 DM, uncontrolled
- ☐ Type 2 DM, new diagnosis
- ☐ Type 2 DM, uncontrolled
- ☐ Gestational diabetes, antepartum (Nutrition only)
- ☐ Renal Disease
- ☐ Renal Insufficiency

Instruct Patient as follows: ____
____

As the physician treating this beneficiary, I certify that the Outpatient Nutritional Services or Medical Nutrition Therapy is medically necessary/desirable as indicated above.

____ ____________________
Physician Signature **Date**

0015813 09/18/18 pt ed