Pacific Clinic of Natural Medicine

Nutrition Referral Form

Instructions: Please fax this completed form to **833-551-4832** along with:

- ❑ Demographic sheet
- ❑ Weight and height history
- ❑ Lab results from the last year
- ❑ Current supplements and medications list

Please call with questions or to coordinate care: 503-894-8977. Thank you for your referral!

Patient Name:_____ Date of Birth: _____/_____/_____

Primary phone number:_____

Insurance:_____ ❑ See Demographic Sheet attached

Commonly used ICD-10 Codes. Please check all that apply and add, alter, or change as needed.

❑ Z68._____: Body mass index (BMI), adult	❑ I10: Essential (primary) hypertension
❑ E66.01: Morbid (severe) obesity due to excess calories	❑ E78.0: Pure hypercholesterolemia
❑ E66.3: Overweight	❑ E78.1: Pure hyperglyceridemia
❑ E66.8: Other obesity	❑ E78.2: Mixed hyperlipidemia
❑ E66.9: Obesity, unspecified – obesity	❑ E78.5: Hyperlipidemia, unspecified
❑ R63.4: Abnormal weight loss	❑ E88.81 : Metabolic syndrome
❑ R63.5: Abnormal weight gain – non preg.	❑ E10._____: Type 1 diabetes mellitus, _____
❑ R63.6: Underweight	❑ E11._____: Type 2 diabetes mellitus, _____
❑ K21.____: GERD	❑ E16.1: Other hypoglycemia
❑ F50.9: Eating disorder, unspecified	❑ E28.2: Polycystic ovarian syndrome
❑ K50.____: Crohn's disease	❑ E03.9 : Hypothyroidism, unspecified
❑ K59.1: Functional diarrhea	❑ R73.01: Impaired fasting glucose
❑ F50.89: Other specified eating disorder	❑ R73.02: Impaired glucose tolerance test
	❑ R73.03: Pre-diabetes
	❑ OTHER _____

Date:

Physician name (printed):_____

Physician signature_____NPI:_____

Group/Practice Name: _____

Office Phone:_____

Office Fax:_____