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

Mandatory: Please check the patient's current diagnosis codes. If they are not listed here, please add or change as needed. Failure to list diagnosis codes may result in no insurance coverage for nutrition therapy. Please DO NOT code for dietary counseling (Z71.3).

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

Date: _____/_____/_____

Physician name (printed):_____

Physician signature_____NPI:_____

Group/Practice Name: _____

Office Phone:_____

Office Fax:_____