

## Nutrition Referral Orange County Health Department

Fax to:  
Orange County Health Department  
Attn: Registered Dietitian: Renée Kemske, MPH, RD, LDN

Chapel Hill Office: 919.245.2418      fax: 919.968.2013  
Hillsborough Office: 919.245.2380      fax: 919.644.3312

### *PATIENT INFORMATION*

Date: _____	
Patient Name: _____	DOB: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Patient Address: _____	
Phone: _____	Medical Provider: _____
Insurance: _____	Medicaid #: _____
Interpreter Needed: <input type="checkbox"/> yes <input type="checkbox"/> no	Parent/Guardian: _____
Referring Office: _____	Contact Person: _____
Office Phone: _____	Office Fax: _____

### *MNT REFERRAL INFORMATION*

Ht: _____ Wt: _____
<b>Reason for MNT Referral (Mark all that apply)</b>
<input type="checkbox"/> Overweight (wt _____ ht _____ BMI _____)
<input type="checkbox"/> Underweight (wt _____ ht _____ BMI _____)
<input type="checkbox"/> Anemia (Hgb/Hct _____)
<input type="checkbox"/> HTN (BP _____)
<input type="checkbox"/> High Cholesterol (TC _____ LDL _____ HDL _____ TG _____)
<input type="checkbox"/> Diabetes (BG _____ A1C _____)
<input type="checkbox"/> Feeding Concerns (Infant/child)
<input type="checkbox"/> Failure To Thrive
<input type="checkbox"/> Allergies/Intolerances
<input type="checkbox"/> Diet Concerns/questions
<input type="checkbox"/> Other (specify) _____

<b>Medical Diagnosis</b> _____
<b>ICD-10 code(s):</b> _____
<b>Clinician Signature</b> _____ <b>NPI#</b> _____

Relevant Labs/Other Data:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Instructions/Comments: _____ _____ _____ _____ _____
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## Medical Nutrition Therapy Referral Process

Thank you for making a Medical Nutrition Therapy (MNT) referral to the Orange County Health Department (OCHD) Registered Dietitians. Your patients are important to us, and we want to ensure that they receive the appropriate care in a timely manner. Please review the following guidelines to make this process both efficient and effective.

- The clinician should complete an MNT referral form that includes the medical diagnoses, the diagnoses codes and clinician's signature. Please indicate on the referral if the patient needs an interpreter. We also accept electronically-generated referrals that include the above requirements.
- Fax the referral to the OCHD; Fax numbers are provided on the referral form. The OCHD is HIPAA compliant, and referrals are received on a secure fax machine.
- Please have your office or the patient call to schedule an appointment: 919.245.2400. When making the appointment, please indicate if the patient needs an interpreter. Limited English Proficiency patients may call the OCHD Spanish voicemail directly if preferred: 919.644.3350.
- Nutrition Services staff will send a follow-up report to the clinician within 30 days of the referral to inform him/her of the status of the referral.
- The RD will fax a report of the MNT appointment to the referring clinician and note any scheduled follow-up appointments.
- If Nutrition Services staff are unable to reach the patient with three or more attempts by phone/letter or the patient declines services, staff will fax this information to the referring clinician to complete the referral process. The clinician may refer the patient again as needed.
- If the patient misses a scheduled appointment, Nutrition Services staff will attempt to re-schedule. Nutrition Services staff will notify the referring practice when a patient misses two consecutive appointments and request that they re-refer as needed.

If you have questions or concerns regarding this process, please feel free to contact Renée Kemske, MPH, RD, LDN, 919.245.2418. Thank you once again for your referral.

Renée Kemske, MPH, RD, LDN  
Registered Dietitian/Licensed Nutritionist

Nutrition Program Manager  
Orange County Health Department  
919.245.2418

