

## 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 Nutrition 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>ICD9 code(s):</b> _____
<b>MD Signature</b> _____ <b>NPI#</b> _____

Relevant Labs/Other Data:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Special Instructions/Comments:
_____
_____
_____
_____
_____