EAT WELL with Gina
nutrition counseling and consulting

Appointment Referral

When referring patients for nutrition services please complete the information below and send to Eat Well with Gina, LLC by emailing contact@eatwellwithgina.com or send with the patient to their scheduled session. Please remind your patients that they must personally contact our office to schedule an appointment.

Date: _____

Patient's Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

Reason for visit: _____

Diagnosis/ICD-9-CM Code(s):

Code: _____ **Diagnosis:** _____

Code: _____ **Diagnosis:** _____

Code: _____ **Diagnosis:** _____

Relevant Lab/Diagnostic Data: (Please attach a copy of the patient's most recent and/or pertinent lab work/tests when submitting this referral)

_____

_____

Medications: _____

Nutrition prescription to be determined by dietitian: **YES** _____ **NO** _____
If NO, please write nutrition prescription here: _____

_____

Activity Restrictions: _____
Additional Comments: _____

This medical nutrition therapy is a necessary part of the patient's medical treatment plan for the diagnosis(es) listed above.

_____ _____
Physician's Signature **Date**

_____ _____
Practice **Phone**

_____ _____
Address **Fax**