East Jefferson General Hospital
Food & Nutrition Services
Outpatient Nutrition Counseling Referral

EJGH Scheduling Dept: Please call patient to schedule appointment

Send to Centralized Scheduling: FAX to: (504) 456-8048 ; Phone: (504) 503-8048
Orders must be faxed before an appointment can be scheduled

Your patient is being referred to a Registered Dietitian for Medical Nutrition Therapy:

**** PLEASE ATTACH A COPY OF THE PATIENT'S HISTORY AND PHYSICAL, CURRENT HEIGHT AND WEIGHT, AND RECENT LABS****

Patient Name: _____ Date of Birth: _____

Phone No.: Home_____ Work: _____ Cell: _____

Medical Nutrition Therapy Orders (Diet Prescription) – Check one or more:

☐ Per Dietitian ☐ Diabetic Diet _____Calorie ☐ Low Fat, Low Cholesterol
☐ Low Sodium (2 gm Na) ☐ Weight Loss/Weight Management _____Calories
☐ Gluten Free Diet ☐ High Calorie/High Protein ☐ Diet for Chronic Kidney Disease –
Specify Protein, Na, K, Phos, fluid amounts: _____
☐ Allergy Diet – specify allergies: _____
☐ Diet for Liver Disease – 2 gm Na, _____ gm Protein, _____cc fluid or ☐ per Dietitian
☐ Diet for Hypoglycemia ☐ Tube Feeding Mgt – Specify: _____
☐ Diet for IBS/UC: _____
☐ Other: _____

Number of Visits Requested*: _____
(*3 – 5 visits over 6 months are recommended to achieve long-term diet/behavioral change.)

Diagnosis(es) and Diagnostic (ICD-10) Code(s) – check one or more and enter appropriate code:**(Required)**

☐ _____ Type 2 Diabetes without complication
☐ _____ Type 1 Diabetes without complication
☐ _____ Type 2 Diabetes, uncontrolled, hyperglycemia
☐ _____ Type 1 Diabetes, uncontrolled, hyperglycemia
☐ _____ Type 2 Diabetes, uncontrolled, hypoglycemia
☐ _____ Type 1 Diabetes, uncontrolled, hypoglycemia
☐ _____ Type 2 Diabetes mellitus with diabetic autonomic (poly) neuropathy
☐ _____ Type 1 Diabetes mellitus with diabetic autonomic (poly) neuropathy
☐ _____ Type 2 Diabetes mellitus with unspecified complications
☐ _____ Type 1 Diabetes mellitus with unspecified complications
☐ _____ Gestational diabetes in pregnancy, unspecified control, (Gestational Age:_____)
☐ _____ Sequelae of protein-calorie malnutrition
☐ _____ Essential primary hypertension
☐ _____ Other (Specify Diagnosis & Code): _____

☐ _____ Type 2 Diabetes with Chronic kidney disease, stage III (moderate)
☐ _____ Type 1 Diabetes with Chronic kidney disease, stage III (moderate)
☐ _____ Type 2 Diabetes with Chronic kidney disease, stage IV (severe)
☐ _____ Type 1 Diabetes with Chronic kidney disease, stage IV (severe)
☐ _____ Type 2 Diabetes with Chronic kidney disease, stage V (NOT ON DIALYSIS)
☐ _____ Type 1 Diabetes with Chronic kidney disease, stage V (NOT ON DIALYSIS)
☐ _____ Type 2 Diabetes with Chronic kidney disease, unspecified
☐ _____ Type 1 Diabetes with Chronic kidney disease, unspecified
☐ _____ Moderate protein-calorie malnutrition
☐ _____ Mild protein-calorie malnutrition
☐ _____ Retarded development following protein-calorie malnutrition
☐ _____ Hyperlipidemia, unspecified
☐ _____ Celiac disease

Patient's Medical Insurance Co: _____ Authorization #: _____

Physician Name: _____ Phone Number: _____
(Please print)

Physician's Signature: _____ Date/Time: _____

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUTPATIENT NUTRITION: (504) 503-4077