

**BAYLOR HEALTH CARE SYSTEM
NUTRITION COUNSELING REFERRAL FORM - OUTPATIENT**

Fax completed referral form, copy of insurance card, and labs to location of your choice

- Baylor Dallas Baylor Ft. Worth (All Saints) Baylor Grapevine Baylor Irving Baylor Plano Baylor Waxahachie
214-818-6897 817-922-1528 817-424-4755 972-579-4355 469-814-6761 972-937-2063

PATIENT INFORMATION & INSURANCE

Patient Name: _____ Date: _____

Phone: (Primary) _____ (Secondary) _____

Address: _____

Last 4 of Social Security Number: Date of Birth: _____

Health Insurance: _____

Policy Holder: _____ Date of Birth: _____

ID/Member Number: _____ Group Number: _____

Pre-certification Phone #: _____ Customer Service #: _____

English-speaking Non-English Speaking (language): _____

DIAGNOSIS Please choose diagnosis and fill in ICD-9 code if needed

- | | |
|--|---|
| <input type="checkbox"/> Impaired Glucose Tolerance (790.21) _____ | <input type="checkbox"/> Pregnancy/lactation _____ |
| <input type="checkbox"/> Obesity (278.00) _____ | <input type="checkbox"/> Gastrointestinal disease _____ |
| <input type="checkbox"/> Morbid obesity (278.01) _____ | <input type="checkbox"/> Renal disease _____ |
| <input type="checkbox"/> Unintentional weight loss _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Eating disorder _____ | <input type="checkbox"/> Hyperlipidemia _____ |
| <input type="checkbox"/> Cardiovascular Disease _____ | <input type="checkbox"/> Other _____ |

PROGRAM REQUESTED

- Medical Nutrition Therapy (Nutrition Counseling)
 Nutrition Counseling Bariatric Assessment
 Pre-insurance Bariatric Screening & Monitoring (____# of visits required by insurance)

LABS Date: _____ Weight _____ Height: _____ Blood Pressure: _____

Fasting Blood Glucose: _____ HemoglobinA1C: _____ Triglycerides: _____

Total Cholesterol: _____ Low Density Lipoprotein: _____ High Density Lipoprotein: _____

Other pertinent labs: _____

Patient is safe to initiate an exercise program. Yes No (please explain) _____

PHYSICIAN

Please Print: _____ NPI: _____

Physician Group Texas Primary Care MedProviders Health Texas Other _____

Telephone: (____) _____ Fax: (____) _____

Physician Signature _____ Date _____ Time _____

Legend: ICD-9 = International Classification of Diseases, 9th edition NPI = National Provider Identifier

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BHCS-49186 (Rev. 08/10)