

NUTRILINK
Consultative Nutrition/Diabetes Services
Referral/Assessment Form Information

Name _____ DOB _____ Date of Referral _____
 Address _____ Home Phone _____ Bus. Phone _____
 Town _____ Zip Code _____

Referring Physician _____ Physician NPI # _____

Please check or state reason for referral:
 Obesity Unintentional Wt Loss/Gain Hypertension Hyperlipidemia
 New Diabetes Uncontrolled Diabetes GDM Pre-Diabetes Hypoglycemia
 GI (IBS, Crohn's, Diverticular Dx, GERD, etc. Be specific: _____)
 Pancreatitis Cholecystitis Liver Dx Renal Dx Eating Disorder
 Other (please specify: _____)

Pertinent Lab Values: (If DM or Hyperlipidemia referral, please note as applicable current
 HgbA1c _____ FBS _____ Trig _____ Chol _____ HDL _____ LDL _____ UMAA _____ ALT _____ AST _____)
 Pertinent Medical Hx: _____

 Physician's Signature: _____ Date _____

ASSESSMENT:

Ht _____ Wt _____ RBW _____ UBW _____ BMI _____ % Body Fat _____

Estimated Needs per day:
 REE (kcal) _____ Kcal/maint _____ Kcal/wt loss/gain _____ PRO _____g Fluid _____cc's
 g/carb/day _____ (%kcal _____) g/pro/day _____ (%kcal _____) g/fat/day _____ (% kcal _____)
 Diet Instruction Complete: Yes No Some Components covered: _____

Material Provided: _____

Pt/S.O. is able to utilize information to plan menus/snacks: Yes No
 Barriers: _____

Recommendations/Comments: (to include expected outcomes, special considerations, social/
 genetic barriers, requests for additional visits or other recommendations for physician consideration)
 Behavioral Goals: _____

Expected Outcomes: _____

Barriers: _____

F/U appointment is scheduled for: _____

REC: _____

RD Signature: _____ Date: _____

Complete the TOP section, sign and FAX form to 508-744-7202 or mail form to: NUTRILINK, 10 Pequod Circle, Yarmouthport, MA 02675. I will call the patient upon receipt, or you or the patient may call 508-561-3691 to schedule the appointment. Patients will be accommodated within one week of referral notification if possible.