Southcoast® Health

Affix Patient Label Here

Outpatient Nutrition Counseling Request Form – SHG

Please call **or** fax Centralized Scheduling to schedule an appointment.
Centralized Scheduling Phone: (508) 973-3900 or (800) 276-0103
Fax: (508)973-3905
Please fax order directly to the site ONLY if the appointment has been scheduled

PLEASE CHECK SITE:
☐ St. Luke's Hospital – 101 Page Street, New Bedford, MA. Fax # 508-973-5166
☐ Tobey Hospital – 43 High Street, Wareham, MA. Fax # 508-273-4346
☐ Durfee Union Complex – 283 Pleasant Street, Fall River, MA. Fax #508-973-5166
☐ Other _____ Fax # 508-973-5166

APPT. DATE: _____ APPT. TIME: _____

PT. NAME: _____

ADDRESS: _____

PHONE: _____ MED REC #: _____ DOB: _____

ORDERING PHYSICIAN: _____PHONE #: _____

PRIMARY CARE PHY: _____

Please check all diagnosis codes that apply:

	250	Diabetes mellitus without complication type II or unspecified type uncontrolled
	251.1	Hyperinsulinism/ Other specified hypoglycemia
	256.4	Polycystic Ovaries
	272.0	Pure hypercholesterolemia
	272.1	Pure hypertriglyceridemia
	278	Morbid obesity
	562.1	Diverticulitis of colon (without hemorrhage)

	564.1	Irritable bowel syndrome
	579.0	Celiac disease
	585.9	Chronic kidney disease, unspecified
	783.0	Anorexia
	783.1	Abnormal weight gain
	783.2	Loss of weight
	783.4	Lack of expected normal physiological development in childhood
	V65.3	Dietary surveillance and counseling

Other diagnosis codes to include:_____

PLEASE FAX PERTINENT LABS/DATA:

☐ For **diabetes** please include HGBA1C, fasting blood glucose, lipids
☐ For **cardiac** please include lipid panel, blood pressure
☐ For **pediatrics** please include growth charts, available lab results
☐ For **malnutrition** please include CBC, available lab results, weight history
☐ For **gastrointestinal diseases** please include results of diagnostic testing

OTHER COMMENTS:

_____

_____

_____

PHYSICIAN SIGNATURE:_____ Date: _____ Time: _____

PCC / APPROVAL / REFERRAL #: _____

Created: 5/14/14 Reviewed: Revised:
FORM# 1300.1550

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