HEALTHY LIVING NUTRITION

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REFERRAL FORM

Thank you for your referral! Please, fax this completed form and additional information as selected below. We will call the referral to schedule an appointment.

Date of Referral: _____

Referring Provider Information

Referring Provider: _____ Specialty: _____ NPI: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____
Referral Coordinator: _____ Email: _____ Ext. _____

Patient Information

Patient Name: _____ DOB: _____ Phone #: _____
Reason for Referral (including ICD-10 diagnosis code): _____
_____

Information Sent with Referral

We ask that at a minimum physicians provide a diagnoses list, medication list, and most recent lab work.

___ Diagnoses List ___ Lab Work ___ Hospital Discharge Summary
___ Medication List ___ Most Recent Progress Note ___ Other: _____

Information Requested

Please, let us know what information you would like to receive regarding this referral.

___ Whether Appt. Was Scheduled ___ Nutrition Recommendations ___ Discharge Summary
___ Nutrition Assessment Summary ___ Periodic Progress Reports ___ Other: _____

Patient Consent

I, _____, understand that I am being referred to Healthy Living Nutrition, LLC for the reason(s) stated above. I give the provider stated above and Lynzi Glasscock, MPH, RDN, LDN permission to mutually share the information identified above.

_____ _____
Patient Signature Date

_____ _____
Provider Signature Date/Time