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## Physician Referral Form for Nutrition Therapy and Weight Management

### Directions to the Patient:

Please complete the **General Information** section and give it to your physician.

### Directions to the Physician:

Please complete and fax these forms to (919) 367-0818

Attention: Cathie Ostrowski, MS, RD, LDN

307 South Salem Street Suite 302

Apex, NC 27502

### General Information --- to be completed by the patient

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_ Telephone (mobile): (\_\_\_\_) - \_\_\_\_\_

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### To be completed by the physician and/or designee:

Referral for Weight Management Intervention & Medical Nutrition Therapy  
for \_\_\_\_\_ (Insert diagnosis and ICD-9 Code)

Clearance to participate in moderate physical activity *without restrictions*.

\_\_\_\_\_

Clearance to participate in moderate physical activity **with the following restrictions:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



### Laboratory Assessment

	Date	Date	Date	Date
Height				
Weight				
Blood Pressure				
Fasting Blood Sugar				
Total Cholesterol				
LDL Cholesterol				
HDL Cholesterol				
Triglycerides				
HgbA1C				

Other lab data, if available:

### Medical Assessment

Condition	Yes	No	Comments
HTN			
Hyperlipidemia			
Cardiovascular disease			
Type 1 Diabetes			
Type 2 Diabetes			
Metabolic Syndrome			
Sleep Apnea			
Asthma			
Arthritis			
Amenorrhea			
Thyroid condition			
GI Disorders			
Gall Bladder Disease			
Renal Disease			
Liver Disease			
Cancer			
Other:			
Other:			



## Psychosocial Assessment

Condition	Yes	No	Comments
History of depression			
Low self-esteem			
Family Problems			
Eating Disorder			
Concerned with weight			
Readiness for behavioral changes needed for weight management:			
Potential barriers to change:			

Medications (name, purpose & dosage):

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**Physician or designee signature**

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**Date**