Lifestyle Management Solutions

Registered Dietitian/Dietetics Services Referral

Thank you for your referral. Please e-mail completed form to: *LMS@GinaCrome.com*

I. Patient Information

Patient Name:	DOB:	SSN:
Parent/Guardian Name (if under 18 years old):		
Home Phone: ( )	Cell: ( )	Email:
Health Insurance:	Policy #:	

What is the reason for this referral?

❑Overweight ❑Obesity ❑Underweight
❑Diabetes ❑Pre-Diabetes ❑Gestational Diabetes
❑Hyperlipidemia ❑Hypertension ❑Metabolic Syndrome
❑Pregnancy ❑Disordered Eating (Specify:_____)
❑Digestive Disorder ❑Other (Specify:_____)

II. Diagnosis

III. Clinical Data

	Type 1 Diabetes uncontrolled (250.3)	ORAL:	
	Type 1 Diabetes controlled (250.01)		
	Type 2 Diabetes uncontrolled (250.02)		
	Type 2 Diabetes controlled (250.00)	INSULIN:	
	Gestational Diabetes (648.83)		
	Complications/Co-morbidities	**Values**	**Date**
	CHD (414.80)	Fasting BG:	
	Chronic Renal Failure (585.): Stage___		
	Gastroparesis (536.3)	OGTT: 1hr____ 2hr____ 3hr____	
	Hyperlipidemia (272.)	Random BG:	
	Hypertension (401.9)	HbA1C:	
	Microalbuminuria/Proteinuria (749.)	Cholesterol:	
	Nephropathy (583.81)	LDL: HDL:	
	Neuropathy (250.6)	Triglycerides:	
	Obesity (278.00)	ALT:	
	Morbid Obesity (278.01)	Creatinine:	
	Pregnancy (648.03)	Microalbumin:	
	Retinopathy (363.0)	Other:	
	TIA (435.90)	Other:	
	Other:	Other:	

Does the patient have any other conditions we should be aware of?

_____

If the patient is taking any other medications, please specify:

_____

Physician/HealthCare Provider Information

Provider Name:	Telephone:
Address:	Email:

_____ _____

Primary Care Provider Signature Date