RETURN FORM VIA FAX: 866-877-2844

ADULT NUTRITION THERAPY REFERRAL

REFERRAL DATE: _____

Referred by:

Provider Name: _____

Clinic Name: _____

Clinic Phone: _____

Clinic Fax: _____

Clinic Address: _____

Referred to:

Provider Name: Elizabeth Woodworth, RD

Clinic Name: Eat Well Nutrition LLC

Phone: 585-210-2644

Fax: 866-877-2844

Address: 114 W Ivy St. East Rochester, NY 14445 AND

95 Allens Creek Rd Bldg 1 Rm 202 Rochester, NY 14618

Patient Details: (Or attach patient facesheet)

Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Home Address: _____

Patient Insurance Details:

Name of Insurer: _____

Name of Subscriber: _____

Relationship to Subscriber: _____

Subscriber ID: _____

X	**Z71.3**: Dietary counseling and surveillance		**I10**: Essential Hypertension
	E66.3: Overweight adult BMI 25-29.9		**R73.03**: Prediabetes
	E66.9: Adult Obesity BMI 30-39.9		**E11.8**: Diabetes Type II
	E66.01: Adult Morbid Obesity BMI 40-49.9		**O24.419**: Gestational Diabetes
	N80.9: Endometriosis, unspecified		**K21.9**: GERD w/o esophagitis
	E78.5: Hyperlipidemia		**K58.9**: IBS, unspecified
	E88.81: Metabolic Syndrome		**Other:** (please include ICD10)

Tips for filling out form:

*Please mark all diagnoses that apply AND include any additional relevant codes.
*You may attach a facesheet in lieu of filling out patient contact and insurance details.
*Please include secondary insurance information if applicable.

PROVIDER SIGNATURE _____

ELLE@EATWELLELLE.COM / WWW.EATWELLELLE.COM

FAX: 866.877.2844 / PH: 585.210.2644