RETURN FORM VIA FAX: 585-282-0044

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 LLC

Phone: 585-210-2644

Fax: 585-282-0044

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

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
	F50.81: Binge Eating Disorder		**K21.9**: GERD w/o esophagitis
	E78.5: Hyperlipidemia		**K58**: IBS
	E88.81: Metabolic Syndrome		**Other:** (please include ICD10)

Tips for filling out form:

*Please mark all diagnoses that apply, NOT only primary concern.

*You may attach a facesheet in lieu of filling out patient contact and insurance details.

*Please include secondary insurance information if applicable.

PROVIDER SIGNATURE _____

EATWELLELLE@GMAIL.COM / WWW.EATWELLELLE.COM

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