Medical Nutrition Therapy Referral Form

Date ________ Referring To (Dietitian and Agency) ________

Referring Agency ________ Referred By ________

SIGN HERE

Authorizing Signature ________ Title, Credentials (Must be licensed healthcare professional) ________

Client Information

Client Name ________ Date Of Birth ________

Ryan White Expiration Date ________ Phone Number ________

Reason for Referral: ☐Hypertension ☐Hyperlipidemia ☐Diabetes ☐Ensure ☐Food Bag/Prepared meals ☐Other

____

Previously seen by Dietitian (RD)? ☐Yes ☐No Previous Dietitian / Agency ________

Nutritional Questionnaire

Question	Answer
Without wanting to, have you experienced significant weight loss or gain in the last 6 months?	Yes☐ No☐
Have you been diagnosed with severe dysphagia (difficulty in swallowing) and/or receive your nutrition via a feeding tube?	Yes☐ No☐
Do you <u>currently</u> have chewing, swallowing or mouth problems (thrush/dry mouth/sores) that make it hard for you to eat?	Yes☐ No☐
Are you on dialysis or have you been diagnosed with any of the following: (circle all that apply) diabetes, renal disease, liver disease/hepatitis, high cholesterol/heart disease, hypertension, cancer, anemia, severe depression, osteopenia, osteoporosis	Yes☐ No☐
Is your CD4 count <u>currently</u> less than 200?	Yes☐ No☐
Were you recently discharged from the hospital and/or are you being treated for an <u>active</u> opportunistic infection?	Yes☐ No☐
Are you pregnant?	Yes☐ No☐
Are any of the following true? Your arms and legs are getting thinner and you can see your veins Your belly is getting bigger Your neck has a hump You have lost your "rear"	Yes☐ No☐
Do you follow a diet regimen for religious, vegetarian or other reasons?	Yes☐ No☐
Most days of the week do you have a poor appetite (little or no desire to eat)?	Yes☐ No☐
Most days of the week do you not have adequate, well balanced meals?	Yes☐ No☐
Are you lactose intolerant and/or have food allergies?	Yes☐ No☐
Most days of the week do you experience one or more of the following: (circle all that apply) diarrhea, constipation, nausea, vomiting, heartburn, bloating/gas	Yes☐ No☐

Attach any additional supporting documents such as labs, clinical visit summaries, medication lists, etc.