PATH OF LIFE NUTRITION
147 Vera Road, Suite E, Lexington, SC 29072
905 Pope Street, Newberry, SC 29108
446 Oak Grove Rd, Boone, NC 28607
Phone: 803-575-0468 | Fax: 803-728-3224 | pathoflifenutrition@gmail.com

NUTRITION REFERRAL FORM

Please fax this completed form along with patient's LABS & pertinent MEDICAL RECORDS to 803-728-3224

*Call **803-399-0212** for questions regarding referrals or referral updates*

OFFICE LOCATION PREFERENCE: **__LEXINGTON OFFICE| __NEWBERRY OFFICE |__BOONE NC OFFICE**

REQUIRED PATIENT INFORMATION

Name: _____ | DOB: _____ | Gender: _____

IF MINOR: Parent/Guardian Name: _____ | Relationship to Patient _____

Address: _____

Phone (H): _____ | (W) _____ | (C) _____

Email: _____ | Preferred Contact Method: _____

Insurance: _____ | Policy #: _____

PRIMARY REFERRAL REASON: _____

(Please check off all pertinent ICD-10 diagnosis codes below; write-in any additional codes in the spaces provided)

__ **Obesity, NOS** E66.9 | __ **Overweight** E66.3 | __ **Morbid Obesity** E66.01 | __ **Abnormal Wt Gain** R63.5 | __ **Underweight** R63.6

__ **Abnormal Weight Loss** R63.4 | __ **Body Mass Index (BMI): _____, adult** Z68.__ | __ **Dietary Counseling/Surveillanc**e Z71.3

__ **Type1 Diabetes w/o comp.** E10.9 | __ **Type2 Diabetes w/o comp**. E11.9 | __ **Prediabetes** R73.03 | __**Gestational Diabetes** O24.4

__ **Eating Disorder NOS** F50.9 | __**Other Feeding Disorders of Infancy & Early Childhood** F98.29 | __**Failure to Thrive** R62.51/R62.7

__ **Food Allergies** K52.2 | __ **Celiac Disease** K90.0 | __ **Non-celiac gluten sensitivity** K90.41 | __ **Nutritional deficiency, unsp.** R63.3

__ **Vitamin Deficiency, unspecified** E56.9 | __ Other: _____

PHYSICIAN INFORMATION

Referring Physician: _____ | Physician NPI Number: _____

Practice: _____

Address: _____

Phone: _____| Fax: _____ | Email: _____

Physician Signature (REQUIRED): _____ | Date: _____
