Referral Form - Outpatient Nutrition Clinic
UPMC Western Maryland Health System
12500 Willowbrook Rd.
Cumberland, MD 21502
Phone: 240-964-8416/ Fax: 240-964-8415

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Day Phone: _____ Evening Phone: _____

Insurance (Attach copy): _____

Referring Physician: _____ Primary Care Physician: _____

Diagnoses to be treated:

__Obesity NOS/ E66.9 __Morbid Obesity/ E66.01 __Overweight/ E66.3 __Weight Gain/ R63.5 __Weight Loss/ R64.3 __Pediatric BMI, $\geq$ 95th percentile for age/ Z68.54 __Underweight/ R63.6 __Malnutrition/ E46 __Anorexia/ F50.00 __Eating Disorder NOS/ F50.9 __Bulimia/ F50.2 __Binge Eating Disorder/ F50.81 __Gout/ M10.9 __Pre-bariatric surgery __Fatty Liver/ K76.0 __Hypoglycemia/ E16.2 __Pre-Diabetes/ R73.03	__Hypertension/ I10 __Hypercholesterolemia/ E78.0 __Hyperlipidemia/ E78.5 __Hypertriglyceridemia/ E78.1 __CKD 3/ N18.3 __CKD 4/ N18.4 __CKD 5/ N18.5 __Diverticulosis/ K57.3 __GERD/ K21.9 __Celiac Disease/ K90.0 __Irritable Bowel Syndrome/ K58 __Crohn's/ K50.9 __Other: Dx and code_____ _____ __Other: Dx and code_____ _____ __ Other: Dx and code_____ _____

Height: ____ Weight: ____

Medical History: _____

_____

Medications (List or attach): _____

_____

Please attach pertinent lab values.

Physician goals for patient: _____

Physician Signature: _____ Date: _____