

Referral Form - Outpatient Nutrition Clinic
UPMC Western Maryland Health System
12501 Willowbrook Rd.
Cumberland, MD 21502
Phone: 240-964-8434/ Fax: 240-964-8231

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Day Phone: _____ Evening Phone: _____

Insurance (Attach copy): _____

Referring Physician: _____ Primary Care Physician: _____

Diagnoses to be treated: (Please select all that apply)

<input type="checkbox"/> Obesity NOS/ E66.9	<input type="checkbox"/> Hypertension/ I10
<input type="checkbox"/> Morbid Obesity/ E66.01	<input type="checkbox"/> Hypercholesterolemia/ E78.0
<input type="checkbox"/> Overweight/ E66.3	<input type="checkbox"/> Hyperlipidemia/ E78.5
<input type="checkbox"/> Weight Gain/ R63.5	<input type="checkbox"/> Hypertriglyceridemia/ E78.1
<input type="checkbox"/> Weight Loss/ R64.3	<input type="checkbox"/> CKD 3a/ N18.31
<input type="checkbox"/> Pediatric BMI, \geq 95 th percentile for age/ Z68.54	<input type="checkbox"/> CKD 3b/ N18.32
<input type="checkbox"/> Underweight/ R63.6	<input type="checkbox"/> CKD 4/ N18.4
<input type="checkbox"/> Malnutrition/ E46	<input type="checkbox"/> CKD 5/ N18.5
<input type="checkbox"/> Anorexia/ F50.00	<input type="checkbox"/> Diverticulosis/ K57.3
<input type="checkbox"/> Eating Disorder NOS/ F50.9	<input type="checkbox"/> GERD/ K21.9
<input type="checkbox"/> Bulimia/ F50.2	<input type="checkbox"/> Celiac Disease/ K90.0
<input type="checkbox"/> Binge Eating Disorder/ F50.81	<input type="checkbox"/> Irritable Bowel Syndrome/ K58
<input type="checkbox"/> Gout/ M10.9	<input type="checkbox"/> Crohn's/ K50.9
<input type="checkbox"/> Pre-bariatric surgery	<input type="checkbox"/> Other: Dx and code _____
<input type="checkbox"/> Fatty Liver/ K76.0	_____
<input type="checkbox"/> Hypoglycemia/ E16.2	<input type="checkbox"/> Other: Dx and code _____
<input type="checkbox"/> Pre-Diabetes/ R73.03	_____
	<input type="checkbox"/> Other: Dx and code _____

Height: _____ Weight: _____

Medical History: _____

Medications (List or attach): _____

Please attach pertinent lab values.

Physician goals for patient: _____

Physician Signature: _____ Date: _____