SAN JUAN REGIONAL MEDICAL CENTER

MNT REF 08/20

Outpatient Medical Nutrition Therapy Note Referral Form

Note: Incomplete referrals will **not** be processed until a complete referral is provided. The number of appointments patients can be seen within a 6 month time period will be at the discretion of the Registered Dietitian. After 6 months from the original referral date, patients will require a new referral.

Patient: _____ **Home Phone:** _____

DOB: _____ **Work Phone:** _____

Guardian: _____ **Primary Language:** _____
(if under 18) *(If other than English)*

Provider: _____ **Provider Phone:**_____

In order to schedule an appointment, the referral must include the following:

- Current height and weight
- Weight history (if applicable)
- Growth Charts (pediatric patients)
- Medical, Physical and Social History
- Labs pertinent to referral diagnosis *(Lab values must be from within the past 3 months)*

Date of Applicable Lab Work _____

T. Cholesterol: _____ Creatinine: _____

Triglyceride: _____ C-reactive Protein: _____

HDL: _____ BUN: _____

LDL: _____ HbA1c: _____
**If ≥6.5%, referral must be sent to Outpatient Diabetes Education.*

Diagnosis/Prescription:_____
****Please refer to the "Appropriate Patient Referrals" form on the SJRMC website for criteria.***

Medications/Supplements:_____

Significant Medical or Social History: _____

Activity Goals/Limitations: _____

For Office Use Only

1st call: _____ **LM NA**

2nd call: _____ **LM NA**

Date and time scheduled: _____

_____ / _____
Provider's Signature Date

_____ / _____
Print Name Medical Office Affiliation

Please fax referral to 505-609-6903. For questions, call 505-609-6139.