

REFERRAL FOR MEDICAL NUTRITION THERAPY

Your patient, named below, is requesting Medical Nutrition Therapy with Lynne W. Scott, MA, RD, LD at Baylor College of Medicine, Houston, TX. A referral from you is required, along with a copy of recent lab work. Please provide the information below and sign. Mrs. Scott can be contacted at 713-798-4150.

Name of Patient: _____ Birthday: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Diagnosis: _____

Diet Order: _____ Lose or gain weight. Ht: _____ Wt: _____

_____ Restrict sodium to _____ mg/ day

_____ Lower cholesterol. Is pt. on cholesterol-lowering medication? _____

_____ Lower triglyceride. Is pt. on triglyceride-lowering medication? _____

_____ Lower glucose. Is pt. on insulin or oral medication? _____

_____ Glucose monitoring

_____ Other: _____

_____ Recent lab report showing lipids and glucose is being faxed to dietitian.

Can patient be encouraged to exercise? Usual plan is to start slow and gradually increase to 30 minutes/day 5 to 7 days/week. Yes _____ No _____

Physician's signature

Date

Physician's address

Physician's telephone

Physician's fax

SEND REFERRAL FORM & LAB REPORT TO: FAX 713-798-6409