ST. JOSEPH
Regional Medical Center
415 6th Street, 3B 03
Lewiston, Idaho 83501

Outpatient Nutrition Services
Physician Referral/Order
Phone: (208) 799-5558

FAX COMPLETED FORM TO: (208) 799-6520

Patient Name:_____ DOB:____/____/____

Contact Phone ( )_____ Work Phone ( )_____

Insurance type:_____ Referring care provider:_____

1. (REQUIRED as available)

Labs: FBS _____ Date:_____
(or 2 hr GTT) _____ Date:_____
Hgb A1C_____ Date:_____
Potassium (K+): _____ Date:_____
Albumin: _____ Date:_____

Lipid Profile (if available):
HDL _____ Date:_____
LDL_____ Date:_____
Cholesterol _____ Date:_____
Triglycerides _____ Date:_____

Medications: (Okay to attach to sheet) _____

2. Diagnosis: (please check appropriate diagnosis)

- ☐ Weight gain
- ☐ Weight loss
- ☐ Obesity
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Pre-diabetes
- ☐ Metabolic Syndrome
- ☐ Cardiovascular disease/arteriosclerosis
- ☐ Other:_____

Instruct Patient as follows: _____

Medical Nutrition Therapy for Diabetes or Renal Disease

(please check appropriate diagnosis)

- ☐ Type 1 DM, new diagnosis
- ☐ Type 1 DM, uncontrolled
- ☐ Type 2 DM, new diagnosis
- ☐ Type 2 DM, uncontrolled
- ☐ Gestational diabetes, antepartum (Nutrition only)
- ☐ Renal Disease
- ☐ Renal Insufficiency

Instruct Patient as follows: _____
_____

As the physician treating this beneficiary, I certify that the Outpatient Nutritional Services or Medical Nutrition Therapy is medically necessary/desirable as indicated above.

_____ _____
Physician Signature **Date**