

# Referral Form



Our best care. Your best health.<sup>SM</sup>

Franciscan Outpatient Nutrition Education Center

**Note to physician:**

**Email to NutritionEducationCtr@chifranciscan.org, fax to (253) 426-6484 or instruct patient to bring it to the appointment. For questions call (253) 426-4926.**

Franciscan Outpatient Nutrition Education Center is located on the St. Joseph Medical Center campus:  
Physicians Medical Center  
1624 South I Street, Suite 205  
Tacoma, WA 98405

Patient name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social security number \_\_\_\_\_

Home phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work phone ( \_\_\_\_\_ ) \_\_\_\_\_

Medical insurance \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Printed name of referring physician \_\_\_\_\_ Office # \_\_\_\_\_

Signature of referring physician \_\_\_\_\_

**Reason for the referral** (please check the appropriate diagnosis)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> COPD                       | <input type="checkbox"/> Hyperlipidemia    | <input type="checkbox"/> Anorexia-bulimia |
| <input type="checkbox"/> Glucose intolerance                | <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> GI disorder      |
| <input type="checkbox"/> Obesity (BMI 30-40)                | <input type="checkbox"/> Morbid obesity (BMI>40)    | <input type="checkbox"/> CHF               | <input type="checkbox"/> CAD              |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Hepatitis/liver disease    |  |   |
| <input type="checkbox"/> Gastric band/bypass diet education | <input type="checkbox"/> Gluten-free diet education | <input type="checkbox"/> Other _____       |   |

**For renal referrals please call (253) 426-6949 • For diabetes referrals please call (253) 426-6753**

Any exercise restrictions?  Yes  No

Comments:

<b>Lab Data</b>	Date drawn: _____		
_____ Total cholesterol	_____ LDL	_____ HDL	_____ Tryglycerides
_____ Glucose	_____ Albumin	_____ HgbA1C	