VANDERBILT UNIVERSITY MEDICAL CENTER
NUTRITION CLINIC REFERRAL FORM
607 Medical Arts Building 1211 21st Avenue, S. Nashville, TN 37232-1320
Phone: (615) 936-3952 FAX: (615) 936-3956

PATIENT:		SS#	MR#
PHONE (H)	(W)	Ht:	Wt:
DOB:	Sex: M F	Diagnosis(es)/ICD-9:	
Referral Date:	Expiration:		
Referral No:		*Please include copy of physician's summary or problem	
No. Visits Approved:	Refer to:	list and pertinent labs and medications.*	

Service requested: ☐ Consultation, Treatment ☐ Other

PRIMARY THERAPEUTIC GOAL(S): (check all appropriate)

☐ improve diet ☐ control type 1 diabetes ☐ reduce lipids ☐ reduce BP
☐ lose weight ☐ control type 2 diabetes ☐ gain weight ☐ control gestational diabetes
☐ other/specific diet order:

NOTES:

PCP:	Phone:	FAX:
Referring MD:	Phone:	
Appointment Date:	Time:	MC 2419 (4/98)