Outpatient Nutrition Referral Form

(for non-HSS referring prescribers)

Instructions

1. Contact your physician (or other prescriber) to complete this form
2. Contact your insurance provider to determine coverage for nutrition counseling
3. Call Outpatient Nutrition at 212.774.7325 for information on how to send this form

Date of Referral: _____

Patient Information

Patient Name: _____ **Patient Date of Birth:** _____

Patient Phone #: _____

Pertinent Medications: _____

DIAGNOSIS AND ICD-10 CODE(S) ARE REQUIRED BEFORE SCHEDULING ANY PATIENT APPOINTMENTS

Reason for Referral: _____

Diagnosis(s): _____

ICD-10 Code(s): _____ _____ _____ _____

Prescriber Information

By completing the information below I certify that I have referred the above patient for outpatient nutrition counseling.

Prescriber Name: _____ **Prescriber NPI#:** _____

Prescriber Signature: _____ **Phone:** _____

Updated 2/1/2024