**HOSPITAL FOR SPECIAL SURGERY**
**Women's Sports Medicine**
**Outpatient Nutrition Counseling Referral**
(To Be Completed by referring physician)

**Physicians may submit form by email to Heidi Skolnik at skolnikh@hss.edu or fax to 212-327-1417**

| **PATIENT RESPONSIBILITIES** |
|---|
| • Contact your insurance provider to determine coverage for nutrition counseling<br>• Call (212) 606-1345 to schedule your nutrition appointment<br>• Bring completed form to your appointment |

Referring Office: _____ Date of Referral: _____

Patient Name: _____ Date of Birth: _____

Phone #: _____ MR# : _____

Insurance: _____

Height: _____ Weight: _____

Pertinent Medications: _____

**PLEASE email or fax** most recent and relevant clinical information, physician notes, prior medical history and relevant labs to Heidi Skolnik at skolnikh@hss.edu or FAX to **212-327-1417**.

**A DIAGNOSIS CODE IS REQUIRED BEFORE SCHEDULING ANY PATIENT APPOINTMENTS**
***Both ICD-9 and ICD-10 codes REQUIRED***

**REASON FOR REFERRAL:** _____

**Diagnosis(es):** _____

**ICD-9 Code(s):** _____ _____ _____ _____

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

**Physician Information:**
*I have referred the above patient for outpatient nutrition counseling:*
***Physician's FULL Name *Required****

Physician Name: _____ Phone: _____

Physician HSS ID#: _____

Physician Signature (REQUIRED): _____

Date: _____