HOSPITAL FOR SPECIAL SURGERY
Outpatient Nutrition Counseling Referral
(To Be Completed by referring physician)

Submit form by email to nutritionreferrals@hss.edu

PATIENT RESPONSIBILITIES
• Contact your insurance provider to determine coverage for nutrition counseling • Call (212) 774-7638 to schedule your nutrition appointment • Bring completed form to your appointment

Referring Clinic/Office:_____ Date of Referral:_____

Patient Name:_____ Date of Birth:_____

Phone #:_____ MRN :_____

Insurance:_____

Height:_____ Weight:_____

Pertinent Medications:_____

PLEASE SEND ELECTRONICALLY most recent and relevant clinical information, physician notes, prior medical history and relevant labs to the Nutrition Department at **nutritionreferrals@hss.edu**.

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

Physician Full Name (REQUIRED):_____

Phone:_____

Physician HSS ID#:_____

Date:_____

Step 1: Print

Step 2: Submit