Blue Ridge Health

Nutrition Services Referral

Patient: _____ DOB (required): _____

Patient Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian: _____ Phone: _____ Email: _____

Parent/Guardian: _____ Phone: _____ Email: _____

Primary Provider: _____ Preferred Dietitian (optional): _____

Primary Provider Phone: _____ Fax: _____

REASON FOR REFERRAL

Diagnosis Code (please include): _____

Please check all that apply:

- ☐ Changes in weight
- ☐ Cardiovascular disease
- ☐ Limited access to adequate nutrition
- ☐ Desire to learn more about healthy eating
- ☐ PCOS
- ☐ Transition eating
- ☐ GI dysfunction (IBS, IBD, Celiac Disease)
- ☐ Gestational Diabetes
- ☐ Diabetes Education
- ☐ Prediabetes
- ☐ Hyperlipidemia
- ☐ Other: _____

Name of Person Sending Referral: _____

Phone Number: _____ Fax Number: _____

Email: _____ Date Referral Submitted: _____

Please fax the completed referral 828.233.2248 or call 828.233.2291 with any questions you may have.

Thank you!