FAX REFERRAL to 480-750-0097
PHONE REFERRAL 480-750-0095
www.aliumhealth.com referrals@aliumhealth.com

Date: _____

Patient Nutrition Program Referral Form

Patient Information*

*If pt. is also being referred for Behavioral Health/Medical Services, only fill-in pt. name & "Referral Information" Section

Name:	DOB:
Phone:	Insurance:
ID #:	Group #:

Priority Level: ☐ Standard (up to 48 hrs) ☐ Priority (up to 24 hrs) ☐ Stat (same day)
☐ Call Patient to Schedule ☐ Patient will Call to Schedule

Referral From*

*skip if already referring pt. for other Alium Health services

Referring Physician Name:	Specialty:
Practice Name:	
Location:	
Phone:	Fax:

Referral Information (Provider Completes)

Clinical Indication for Services Requested:
☐ Medical Nutrition Therapy (MNT) ☐ Multiples (twins, etc.) Program ☐ Celiac Program ☐ Gastric Bypass

Diagnoses (check ALL that apply)		CPT Codes
☐ E10.65: Type 1 diabetic, uncontrolled	☐ N18.4: CKD, Stage IV (GFR 15-29)	☐ 97802: Initial Assessment
☐ E11.65: Type 2 diabetic, uncontrolled	☐ N18.5: CKD, Stage V (GFR <15)	☐ 97803: Follow-Up or Re-assessment
☐ E10.9: Type 1 diabetic, controlled	☐ E78.2: Hyperlipidemia	☐ 97804: Group nutritional therapy
☐ E11.9: Type 2 diabetic, controlled	☐ E66.9: Obesity	
☐ R73.01 Impaired fasting glucose	☐ E66.01: Morbid obesity	
☐ Q24.419: Gestational diabetes	☐ Z91/018: Allergy to other foods	
☐ I10: HTN, essential, benign	☐ Other: _____	
☐ N18.3: CKD, Stage III (GFR 30-59)	☐ Other: _____	

Exercise Recommendations: ☐ Mild (1-2 days) ☐ Moderate (3-4 days) ☐ High (5+ days) ☐ None

Weight Recommendations: ☐ Weight Gain: _____ ☐ Lbs. ☐ Cals/day
☐ Weight Loss: _____ ☐ Lbs. ☐ Cals/day

Foods for Patient to Avoid:

PROVIDER SIGNATURE: **DATE:**

Authorization/referral valid until:

PLEASE REMEMBER TO INCLUDE IN FAX/P2P: ☐ Referral Form(s) ☐ EPDS ☐ Chart Note ☐ Demographics

PRINT NAME of person completing form Date

WE KINDLY REQUEST THAT YOU SEND ALL PERTINENT MEDICAL RECORDS