SWEDISH MEDICAL CENTER

SWEDISH NUTRITION CARE CLINICS PHYSICIAN REFERRAL FORM

Patient Name: _____ **Patient phone number:** _____
Physician Name: _____ **Physician phone number:** _____
Physician Address: _____
Reason for nutritional referral: _____

Please indicate all relevant diagnostic codes:

Most common codes		Other codes	
Blood sugar, abnormal, high	790.2	Anemia, unspecified	280.9
Celiac Sprue	579.0	Atherosclerosis, unspecified	440.9
Colitis, NOS	558.9	Crohn's Disease, NOS	555.9
Diabetes Mellitus, type II	250.00	Dumping syndrome	564.2
Dietary surveillance & counseling	V65.3	Diverticulitis of colon w/o hemorrhage	562.11
Fatty liver/NASH	571.8	Diverticulosis of colon w/ hemorrhage	562.12
Hyperlipidemia, mixed	272.2	Dysphagia	787.2
Hypertriglyceridemia	272.1	Failure to thrive, infant	783.41
Hypertension, benign	401.1	Fatigue	780.79
Irritable Bowel Syndrome	564.1	Food Allergy	V15.0
Malignant neoplasm, by site _____		Gallbladder disorder, unspecified	575.9
Metabolic Syndrome	277.7	Lactose intolerance	271.3
Obesity/Overweight		Gout, unspecified	274.9
Unspecified	278.00	Grave's disease	242.00
Morbid	278.01	Hypoglycemia	251.2
Overweight	278.02	Hypercholesterolemia, pure	272.0
Obstetrical, antepartum		Hypothyroidism, unspecified	244.9
Abnormal GTT (gestational diabetes)	646.83	Malnutrition, protein/calorie	
Edema/excessive weight gain	646.13	Mild	263.1
Hyperemesis	643.03	Moderate	263.0
Pre-diabetes	790.29	Unspecified	263.9
Reflux	530.81	Meniere's Disease, unspecified	386.00
Renal failure, chronic	585	Pancreatitis, chronic	577.1
Ulcerative colitis	556.9	Polycystic ovarian disease	256.4
Weight gain, abnormal	783.1	Sleep Apnea	780.57
Weight loss, abnormal	783.21	Ulcerative colitis	556.9
Other diagnostic codes:			

Current Weight: _____ **Height:** _____ **Blood Pressure:** _____/_____

Please include a copy of any relevant laboratory tests.

Please fax this form to (206) 781-6196, mail it to the address below, or have the patient call (206) 781-6228 to schedule an appointment.

Mailing Address:
Swedish Medical Center
Nutrition Care Clinic
5300 Tallman Ave. N.W.
Seattle, WA 98107-1507

Physician signature: _____ **Date:** _____