HEALTHier U

Dietician/Nutritionist Referral

Referring Physician:_____ Date:_____

Address:_____

Phone:_____ Fax:_____ Office Contact:_____

Diagnosis for Medical Nutrition Therapy Services

☐ 278.00- Obesity NOS (BMI 30-39.9)

☐ 278.01- Obesity Severe (BMI>40)

☐ BMI <30 but at risk for Chronic Disease
List disease_____

Patient Name:_____ Participant Name:_____ ID#_____

DOB:_____ Phone:_____

Address:_____

Weight:_____ BMI:_____ Waist Circum:_____

BP:_____

HDL:_____TC/HDL Ratio:_____

Glucose (if applicable)(results within past 6 months acceptable):_____

Cholesterol:_____

Chosen Provider:

☐ **Anders & Dunaway Nutrition Consultants**
2121 E. Flamingo Road #114
Las Vegas, NV 89119
Phone (702) 382-8841
Fax (702) 369-2370

☐ **Nutrition by Joey** (Choose location)
8275 S. Eastern Aveue #118
Las Vegas, NV 89123
6140 S. Forte Apache Road #100
Las Vegas, NV 89148
Phone (702) 878-5639
Fax (480) 247-4491

☐ **Nutrition Moves!**
7721 Leavorite Drive
Las Vegas, NV 89128
Phone (702) 242-5730
Fax (702) 242-1417

☐ **Medical Nutrition Specialists**
1580 E. Desert Inn Road #201
Las Vegas, NV 89169
Phone (702) 574-3480
Fax

☐ **Diabetes Management Consultants**
9680 W. Tropicana Avenue #110
Las Vegas, NV 89147
Phone (702) 997-6474
Fax (702) 847-5885

Give copy to patient, fax to chosen provider & Culinary Health Fund Wellness Dept. at 702-691-5682

Culinary Health Fund™

INITIAL RESULTS FROM REFERRED PROVIDER

Date: _____

Weight: _____ **BP:** _____

BMI: _____ **Waist Circum:** _____

Cholesterol: _____ **HDL:** _____

TC/HDL Ratio: _____

Glucose (if applicable): _____

(results within past 6 months acceptable)

Referring Physician: _____ Phone: _____ Fax: _____

Health Risk Assessment / Date Completed: _____

Patient First Name: _____ Last Name: _____

Date of Birth: _____ Sex: _____

Date of Visit	Weight	BMI	Waist Circum.	BP
Next Appt: ____/____/____	Notes:			
Next Appt: ____/____/____	Notes:			
Next Appt: ____/____/____	Notes:			
Next Appt: ____/____/____	Notes:			
Next Appt: ____/____/____	Notes:			

Patient First Name: _____ Last Name: _____

Date of Visit	Weight	BMI	Waist Circum.	BP
Next Appt: ____/_____/____	Notes:			
Next Appt: ____/_____/____	Notes:			
Next Appt: ____/_____/____	Notes:			
Next Appt: ____/_____/____	Notes:			
Next Appt: ____/_____/____	Notes:			