REFERRAL/ORDER FORM
CLINICAL NUTRITION

Connecticut Children's MEDICAL CENTER

Connecticut Children's Patient Label
for internal use only

Patient Name: (Last) _____ (First) _____

Street Address: _____

City/State/Zip: _____ **Date of Birth:** _____

Preferred Phone: (Home) _____ (Work) _____ (Cell) _____

Parent/Guardian/DCF: _____ **Preferred Language:** _____

If DCF: (Social Worker name) _____ (Phone) _____

This visit is: ☐ Routine ☐ Semi-urgent (within 2 weeks) **Urgent: Please call Department for urgent appointments.**

Insurance: _____ **ID#** _____

These are the ICD code most commonly used: *E44.1 Mild Malnutrition, E44.0 Moderate Malnutrition, E46 Unspecified Malnutrition, R62.51 Failure to thrive in childhood or Failure to gain weight, R63.0 Anorexia, F50.00 Anorexia Nervosa, F50.2 Bulimia Nervosa, Z91.010 Allergy to Peanuts, Z91.018 Allergy to other foods, L27.2 Dermatitis due to food taken internally, E66.9 Obesity unspecified, E66.01 Morbid Obesity, E88.89 other unspecified metabolic disorders, E73.9 Intestinal disaccharidase deficencies and disaccharide malabsorption*

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Reason for referral/background _____

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Please fax demographics, growth charts and labs with referral to 860.837.6283.
For questions, please contact us at 860.837.6286.

REFERRING PROVIDER INFORMATION

Referring Provider: _____

Referring Provider: (Phone) _____ (Fax) _____

Patient's Primary Care Physician (if different from referring)**:** _____

Is the family aware of the reason for referral? ☐ Yes ☐ No

_____ Date _____ Time _____

Signature/Credentials of ordering Practitioner (APRN, PA, Non-resident MD or DO)