Shae Foudy LLC

THE PEDIATRIC RD

PEDIATRIC NUTRITION REFERRAL FORM

Telehealth Pediatric Nutrition Services for Hawai'i Families

949-300-9775 shaefoudyllc@gmail.com Fax: 808-791-4169

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Phone Number: _____

Email Address: _____

Primary Insurance: _____

Secondary Insurance (if applicable): _____

REFERRING PROVIDER INFORMATION

Provider Name: _____

Clinic/Practice: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

REASON FOR REFERRAL (Check all that apply)

- ☐ Starting Solids / Infant Feeding
- ☐ Food Allergies or Food Intolerances
- ☐ Picky Eating / Selective Eating
- ☐ Poor Weight Gain / Growth Concerns
- ☐ Failure to Thrive
- ☐ Overweight / Obesity
- ☐ Pediatric Gastrointestinal Concerns (Constipation, Reflux, Diarrhea)
- ☐ Tube Feeding Support
- ☐ Sports Nutrition
- ☐ Diabetes / Prediabetes
- ☐ Celiac Disease
- ☐ General Pediatric Nutrition Counseling
- ☐ Other: _____

RELEVANT DIAGNOSES / CLINICAL CONCERNS

_____

_____

_____

_____

PLEASE INCLUDE THE FOLLOWING IF AVAILABLE

- ☐ Most recent growth charts
- ☐ Recent height and weight measurements
- ☐ Relevant laboratory results
- ☐ Medication list
- ☐ Recent clinic/progress notes
- ☐ Feeding therapy evaluations
- ☐ Speech therapy evaluations
- ☐ Occupational therapy evaluations
- ☐ GI, Allergy, Endocrinology, or other specialist notes
- ☐ Other relevant records

ADDITIONAL COMMENTS

_____

_____

_____

_____

URGENCY OF REFERRAL (Check one)

- ☐ Routine (within 2–4 weeks)
- ☐ Priority (within 1–2 weeks)
- ☐ Urgent nutrition concern

REFERRAL SUBMISSION

Please fax this completed referral form and any relevant medical records to:

Fax: 808-791-4169

Families may also self-schedule directly through the online booking portal at www.shaefoudy.com.

ACCEPTED INSURANCE PLANS

- HMSA
- HMAA
- UHA

Additional insurance plans may be accepted.
Please contact the office to verify current coverage.

Thank you for your referral!