Shae Foudy LLC

THE PEDIATRIC RD

PEDIATRIC NUTRITION REFERRAL FORM

Medical Nutrition Therapy for Hawai'i Children & Families

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

PATIENT INFORMATION

Patient name: _____

Date of birth: _____

Parent/guardian name: _____

Phone number: _____

Email address: _____

PRIMARY INSURANCE

Insurance company: _____

Policy holder name: _____

Policy holder DOB: _____

Member ID: _____

Secondary insurance: _____

Insurance card copy (front & back) attached

REFERRAL NEED

Initial nutrition referral

Additional referral for change in condition / treatment plan

Other / follow-up referral

REASON FOR REFERRAL

Feeding difficulty / pediatric feeding disorder

Poor weight gain / growth faltering

Food allergy / intolerance / EoE

GI concerns (constipation, reflux, diarrhea, celiac)

Tube feeding / enteral nutrition support

Diabetes / dyslipidemia / cardiometabolic concern

Overweight / obesity

Nutrient deficiency / other medical nutrition concern

MEDICAL DIAGNOSIS + ICD-10 CODE(S)

Please list the medical diagnosis(es) supporting nutrition services.

Include the corresponding ICD-10 code for each diagnosis.

Diagnosis: _____ ICD-10: _____

Diagnosis: _____ ICD-10: _____

Medical necessity note:

Patient is referred for nutrition services as a medically necessary part of medical treatment and/or prevention of complications for the diagnoses listed.

PLEASE INCLUDE THE FOLLOWING

Most recent office / medical note

Growth charts and recent weights / heights

Relevant laboratory results

Medication and supplement list

Feeding / speech / occupational therapy evaluations, if relevant

GI, Allergy, Endocrinology, or other specialist notes, if relevant

Other records relevant to the nutrition concern

ADDITIONAL CLINICAL INFORMATION

Urgency: Routine (2-4 weeks) Priority (1-2 weeks) Urgent

Insurance / coding reminder

Accepted plans: HMSA, HMSA QUEST, HMAA, and UHA.

Coverage varies by plan; include the underlying medical diagnosis with any BMI Z-code.

REFERRING PROVIDER INFORMATION

Provider name: _____ Clinic / practice: _____

NPI: _____ Phone: _____ Fax: _____

Provider email: _____ Referral date: _____

Referring provider signature: _____ Credentials: _____

REFERRAL SUBMISSION

Please fax this completed referral form and applicable records to:

FAX: 808-791-4169

Questions?

949-300-9775

shaefoudyllc@gmail.com