University Hospitals
Cleveland Medical Center

UHCMC Outpatient Pediatric Clinical Nutrition

Medical Nutrition Therapy (MNT) Referral Form

PLEASE CALL TO SCHEDULE: (216) 844-1499; FAX: (216) 844-7013

Pediatric Nutrition Services Locations: W.O. Walker, Landerbrook Health Center, Medina Health Center, Solon Health Center, or St. John Medical Center RBC Pavilion

Patient's Name:________________________________ **Date:**________________ **DOB:**________________
Patient's Phone:________________________________
Medical Record Number: ________________________

DIAGNOSIS (required)-select diagnosis

- ☐ R63.4 **Abnormal Loss of Weight and Underweight**
- ☐ R62.51 **Failure to Thrive**
- ☐ R63.3 **Feeding Difficulties**
- ☐ Z91.010 **Peanut Allergy**
- ☐ Z91.011 **Milk Allergy**
- ☐ Z91.012 **Egg allergy**
- ☐ Z91.018 **Multiple Food Allergies**
- ☐ K90.0 **Celiac Disease**
- ☐ E55.9 **Vitamin D Deficiency, unspecified**
- ☐ Z93.1 **Gastronomy status, G tube**
- ☐ E66.3 **Overweight**
- ☐ E66.9 **Obesity, unspecified**
- ☐ Z68.__ __ **BMI**_______
- ☐ R63.5 **Abnormal Weight Gain**
- ☐ E78.00 **Pure Hypercholesterolemia, unspecified**
- ☐ E78.2 **Hyperlipidemia, mixed**
- ☐ I10 **Hypertension**
- ☐ R73.03 **Pre-diabetes**
- ☐ Z78.9 **Ketogenic Diet**
- ☐ G40.909 **Epilepsy, unspecified**

****Other DX and ICD-10 Code/s (specify):** ____

GROWTH AND LABORATORY DATA

Current: Wt: ___________ Ht: __________

Include pertinent growth history:____
Current feeding regimen:____
Glomerular Filtration Rate: ___________ OR Serum Creatinine: ______________
Fasting Blood Glucose (> 126 mg/dl): ____________ HgbA1C:____________
Total Cholesterol: ____________ HDL:_________ LDL: ________________
Triglycerides: ________________ BP:___________
*Please attach any other labs if necessary

DIET PRESCRIPTION

- ☐ Weight Reduction
- ☐ Weight Gain
- ☐ High Fiber
- ☐ Modified Consistency:________________
- ☐ Food Allergy:______________________
- ☐ Carbohydrate Counting
- ☐ Low Cholesterol / Low Fat
- ☐ 2 gram sodium
- ☐ Other:____

____

****Weight Loss Referrals -Clearance for Exercise Yes No (Circle One)**

Comments:____

Physician Name (print):____

Physician Signature:____

Physician Phone/Fax:____________________________

*Physician- retain original and fax a copy to the dietitian.