SKYLINE HOSPITAL

DIETITIAN OUTPATIENT REFERRAL

FAX: 509-493-1368
PHONE: 509-637-2810

REFERRING PROVIDER: _____ **PHONE:** _____

PATIENT NAME: _____ **M / F** **D.O.B.** _____

ALLERGIES: _____

HT (INCHES): _____ **WT (KG):** _____ **BMI:**_____ **BP:**_____ **HgbA1c**_____

PT PHONE #: _____ _____

DIAGNOSIS:

_____

_____

ICD 10 CODE: _____

TYPE OF SERVICE:

☐ MEDICAL NUTRITION THERAPY

☐ DIABETIC EDUCATION

☐ OTHER_____

REFERRAL CHECKLIST

***please check the appropriate boxes and include required documents along with this form**

☐ PRE-AUTHORIZATION COMPLETE (**AUTH #)** _____

☐ DEMOGRAPHIC

☐ LAB RESULTS

☐ SPECIALTY and/or PCP NOTES

☐ PCP NOTES

☐ GROWTH CHARTS

PACKET COMPLETE AND FAXED TO SKYLINE MEDICAL CLINIC

PROVIDER SIGNATURE: _____DATE: _____TIME: _____

*Skyline staff will contact the patient confirming their procedure date & time

Approved by _____

6.15.18