**Western Maryland Nutrition Referral Form**

Fax completed form to: 301-876-7222.

Please call 301-338-1678 with any questions or concerns.

Patient Name: _____ Date of Birth: _____

Primary Phone: _____ Secondary Phone: _____

Address: _____

Referring Provider: _____Referring provider NPI: _____

Primary Care Provider (if different than referring): _____

Insurance carrier (attach copy): _____

Height: _____ Weight: _____

**Referral diagnosis*** (check all that apply, more specific codes may help improve reimbursement):

| | |
|---|---|
| __Anorexia nervosa, unspecified severity: **F50.019**<br>___mild (BMI >17) **F50.010**<br>___moderate (BMI 16-16.99) **F50.011**<br>___severe (BMI 15-15.99) **F50.012**<br>___extreme (BMI <15) **F50.013**<br>__Bulimia nervosa, unspecified: **F50.20**<br>___mild (1-3 episodes/week) **F50.21**<br>___moderate (4-7 episodes/week) **F50.22**<br>___severe (8-13 episodes/week) **F50.23**<br>___extreme (≥14 episodes/week) **F50.24**<br>__Binge eating disorder, unspecified: **F50.819**<br>___ mild (1-3 episodes/week) **F50.810**<br>___moderate (4-7 episodes/week) **F50.811**<br>___ severe (8-13 episodes/week) **F50.812**<br>___extreme (≥ 14 episodes/week) **F50.813**<br>__ARFID **F50.82** | __Eating disorder not otherwise specified **F50.9**<br>__Obesity **E66.9**<br>__Overweight **E66.3**<br>__Weight Loss **R64.3**<br>__Weight Gain **R63.5**<br>__Underweight **R63.6**<br>__Protein/Kcal Malnutrition, unspecified **E46**<br>__Other: _____<br>__Other: _____<br>__Other: _____ |

*Severity is now based on provider's clinical judgment rather than BMI or # of episodes.

Past Medical History: _____

_____

_____

Medications:

_____

Physician goals/other relevant info:

_____

_____

_____

**Please attach relevant labs and most recent progress notes as well as insurance info.**

Physician signature: _____Date:

**_____**