

Western Maryland Nutrition Referral Form

Fax completed form to: 301-872-7222.

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 ☐ mild (BMI >17) F50.010 ☐ moderate (BMI 16-16.99) F50.011 ☐ severe (BMI 15-15.99) F50.012 ☐ extreme (BMI <15) F50.013 ☐ Bulimia nervosa, unspecified: F50.20 ☐ mild (1-3 episodes/week) F50.21 ☐ moderate (4-7 episodes/week) F50.22 ☐ severe (8-13 episodes/week) F50.23 ☐ extreme (≥14 episodes/week) F50.24 ☐ Binge eating disorder, unspecified: F50.819 ☐ mild (1-3 episodes/week) F50.810 ☐ moderate (4-7 episodes/week) F50.811 ☐ severe (8-13 episodes/week) F50.812 ☐ extreme (≥ 14 episodes/week) F50.813 ☐ ARFID F50.82	☐ Eating disorder not otherwise specified F50.9 ☐ Obesity E66.9 ☐ Overweight E66.3 ☐ Weight Loss R64.3 ☐ Weight Gain R63.5 ☐ Underweight R63.6 ☐ Protein/Kcal Malnutrition, unspecified E46 ☐ Other: _____ ☐ Other: _____ ☐ Other: _____
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*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: _____