Brookings
HEALTH SYSTEM

Medical Nutrition Therapy Referral Form

(For Non-Diabetic Referrals)

Client's Name:____ **D.O.B:**________________
If Child, Parent's Name:____
Phone:___________________ **Cell Phone:**________________ **Work Phone:**__________________

Referring Clinician:____
Nurse Contact Name:________________ **Phone Number:** ____________**Fax Number:**__________
Referral Reason:

- Special Diet Education:______________________________
- Weight Management
- Insulin Resistance/Glucose Intolerance
- Childhood Weight Management Program
  - BMI Percentile______________________________
- Unintentional Weight Loss
- Other (please specify):______________________________

Primary Diagnosis (related to referral reason):____
____

Pertinent Medications:____
____

Height: ____________________ **Weight:** ____________________

Related Lab Data (if necessary): (Please write in labs or attach lab results)

Date	Lab	Result	Date	Lab	Result
	Sodium			Glucose	
	Potassium			Total Cholesterol	
	BUN			HDL Cholesterol	
	Creatinine			LDL Cholesterol	
	Albumin			Triglycerides	

Clinician Signature:____**Date:**______________

Please Fax Referral to Brookings Health System Centralized Scheduling @ 605-696-8889.

*If you have a question regarding referrals or services from the dietitian, please call Katy VanderWal, RD, LN (605-696-7789):
*If you have questions regarding outpatient registration, please call Centralized Scheduling (605-696-8888)