Brookings
HEALTH SYSTEM

300 22nd Avenue
Brookings, SD 57006
Phone: (605) 696-9000
Fax: (605) 696-8822

PHYSORD

PATIENT LABEL

Medical Nutrition Therapy Referral Form

Patient Name: _____ **DOB:**_____
If Child, Parent's Name: _____
Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Referring Clinician: _____
Nurse Contact Name: _____ **Phone Number:** _____ **Fax Number:** _____
Referral Reason:

- ○ Diet Education: _____
- ○ Tube Feeding Management
- ○ Other (please specify): _____

Diagnosis (related to referral reason): _____
_____

Pertinent Medications: **Attach if pertinent to referral**
Lab Data: **Please attach if pertinent to the referral**

Height: _____ **Weight:** _____

Special Needs: _____
(Language, hearing/speech/vision, learning)

Exercise/Activity Plan (if applicable): _____

- ○ **Release:** _____
- ○ **Not Released:** _____

Additional Information (if necessary)**:** _____
_____
_____
_____
_____

Time:_____ Date:_____ Clinician Signature: _____

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 (605-696-8027).

*If you have questions regarding outpatient registration, please call Centralized Scheduling (605-696-8888)