PeaceHealth Medical Group
Pediatric Medical Nutrition
Tok-Hui Yeap, RD, CSP, LD

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Springfield, OR 97477
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REFERRAL FORM

Fax this form including the following documents to 541-349-5560:

☐ **Demographic sheet** ☐ **Pertinent medical records and labs** ☐ **Insurance authorization**

☐ **REFERRAL TO MEDICAL NUTRITION THERAPY** ☐ Routine ☐ Urgent (REQUIRES CALL)

☐ Initial MNT: 3 hrs ☐ Follow-up MNT: 2 hrs ☐ 2nd referral/calendar year: 2 hrs

Diagnosis: ICD 10:

Comments:

PATIENT INFORMATION

Patient Name: Date of Birth: / /

Street Address: City: State:

Primary Phone: Alternate Phone:

Parent/Guardian(s):

Interpreter Needed: ☐ No ☐ Yes; Language Needed:

Insurance: Member #:

Authorization #: Notes:

Primary Care Provider:

REFERRING PROVIDER INFORMATION

Name: Signature: Date:

Clinic: Office Contact:

Phone: Fax: