

Consultation with Registered Dietitian / Certified Diabetes Educator requested for:

<u>Patient's:</u> Name: _____ Phone #: _____ DOB: ____/____/____

Please check reason for visit and/or specify below:

WEIGHT MANAGEMENT:

- _____ Overweight
- _____ Underweight
- _____ Weight Cycling

NUTRIENT DEFICIENCY:

- _____ Calcium
- _____ Iron
- _____ Other: _____

BLOOD PRESSURE MANAGEMENT:

- _____ Hypertension
- _____ Hypotension

HYPERLIPIDEMIA:

- _____ High LDL
- _____ Low HDL
- _____ High TG

RENAL:

- _____ Low Potassium Diet
- _____ High Potassium Diet
- _____ Fluid Restriction
- _____ Protein Restriction

BLOOD SUGAR MANAGEMENT:

- _____ Newly diagnosed with Diabetes
- _____ Prediabetes
- _____ Diabetes Education
- _____ Meter training & target goals
- _____ Insulin start/change
- _____ Byetta Training
- _____ Pump start

DIGESTIVE:

- _____ IBS
- _____ Food allergies
- _____ Crohn's Disease
- _____ Celiac Sprue

OTHER:

EATING DISORDER:

- _____ Anorexia
- _____ Bulimia
- _____ Binge Eating Disorder
- _____ Non-specified

Please fax this form to PIONEER VALLEY NUTRITION at (413) 584-2255

<u>Physician's:</u> Name: _____ Phone #: _____ Fax #: _____

