dell children's
medical center of central texas
A member of the Seton Family of Hospitals

Pediatric Outpatient Nutrition Referral

Complete, Sign, and Fax to (512) 406-6520

Have the parent/guardian call (512) 324-0137 to schedule an appointment.

Patient Name: _____ Preferred language: _____

Age: _____ DOB: _____ Sex: M F (circle one) Date of measurements: _____

(Please circle unit.) Height: _____ (cm or in) Weight: _____ (kg or lb) BMI (kg/m^2): _____

Medications:_____

Parent/Guardian Name: _____ Mobile Phone #: _____

Patient's Home Address: (street, city, zip)_____

Insurance:_____ Policy# _____

Referring Physician Name: _____

Referring Physician Office Phone: _____ Referring Physician Fax: _____

Primary Care Physician Name:_____

REQUIRED: We require this Referral Form to be FULLY completed or referral will be rejected. Please include the last clinical notes, lab work and growth charts if available with referral.

Reason For Referral (Please check all that apply)

- ☐ **R63.5** Abnormal Weight Gain
- ☐ **E66.3** Overweight
- ☐ **E66.8** Obesity
- ☐ **R63.4** Abnormal Weight Loss
- ☐ **R63.6** Underweight
- ☐ **R62.51** Failure to thrive, child
- ☐ **Z93.1** Enteral Nutrition/Gastrostomy/Tube Feeding
- ☐ **K76.0** Fatty Liver Disease
- ☐ **E78.5** Hyperlipidemia, unspecified
- ☐ **R63.3** Oral Aversion/Feeding Difficulties
- ☐ **K.90.0** Celiac disease
- ☐ **K52.2** Food Allergies/Intolerance
- ☐ **I10** Hypertension, Essential (Primary)
- ☐ **D64.9** Anemia, unspecified
- ☐ **K59** Constipation
- ☐ **R73.03** Prediabetes
- ☐ **F50.9** Eating Disorder, unspecified
- ☐ **F50.00** Anorexia Nervosa, unspecified
- ☐ **F50.8** Other Eating Disorders
- ☐ **F50.2** Bulimia Nervosa, unspecified
- ☐ **Z71.3** Dietary counseling and surveillance

_____ _____

Referring Physician (signed) Date