CONSULTATION FORM

Date: _____

Nutrition & Diabetes Education Center LLC
12150 Annapolis Rd. Ste 104
Glenn Dale, Maryland 20769
301-805-8292
Email: shawks@nutrition-diabetes.com

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____ Phone: _____

Patient's Address: _____

MEDICAL NUTRITION THERAPY: See Registered Dietitian/Nutritionist

☐ Hypertension	☐ Anemia (Iron Deficiency)
☐ Hypercholesterolemia	☐ Celiac Disease, Gluten Sensitivity
☐ Obesity	☐ Hypothyroidism or Hyperthyroidism
☐ Wt Management	☐ Heart Disease
☐ Eating Disorders	☐ Food Allergies
☐ GERD, IBS, Chrohn's Disease	☐ Other _____

DIABETES CONSULTANT AND TREATMENT: See Certified Diabetes Educator

Diagnosis:	**Reason For Referral (check all that apply)**
☐ Type 1	☐ Newly diagnosed diabetes
☐ Type 2	☐ A1C > 7% _____
☐ Pre-diabetes	☐ New to insulin
☐ Gestational Diabetes	☐ High risk for complications
☐ Renal Disease	☐ Individual Diabetes Education
☐ Other _____	☐ Diabetes Self Management Training (DSMT)

Referring Provider: _____

Phone: _____ Fax: _____

To schedule appointment, please call 301-805-8292
Please bring referral and latest lab work

Note: This form may not be authorized as an official referral form from your insurance provider.