NATURAL STATE
nutrition professionals LLC

# REFERRAL ORDER

Referring Provider: _____ Clinic: _____

Patient Name: _____ DOB: _____

Diagnosis / Diagnosis code: _____

**For Diabetes Education, please state: Full initial training, up to 10 hours. Individual training required.**

TO ENSURE TIMELY PROCESSING, PLEASE INCLUDE THE FOLLOWING INFORMATION.

- Patient's insurance information, including carrier name, subscriber ID and group #
- Last encounter note and most recent labs – CBC, CMP, lipids, A1C, any others relevant to referral dx
- List of current medications

Patient Address: _____

Patient Phone Number: _____ Preferred Language: _____

Physician's Office Contact Name: _____

Physician's Office Contact Email and / or Fax #: _____

We will attempt to contact the patient three times before the referral is closed. If you have questions about the status of a referral, please feel free to contact our office.

Referring Provider Signature: _____

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