



Pediatric Outpatient Registered Dietitian  
2018 Clinch Ave, Knoxville, TN 37916  
Phone: (865) 541-8755 • Fax: (865) 246-7571

# Outpatient Nutrition Order

Patient's Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Language (if not English): \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

### Reason for Medical Nutrition Therapy:

- Failure to thrive/weight loss
- Overweight/obesity
- Enteral Nutrition Management
- Food allergies (specify): \_\_\_\_\_
- Other \_\_\_\_\_

### Patient Information:

Height: \_\_\_\_\_ Circle: cm or in

Weight: \_\_\_\_\_ Circle: kg or lbs

BMI: \_\_\_\_\_

Medications: \_\_\_\_\_

Pertinent labs: Trig \_\_\_\_\_ Chol \_\_\_\_\_ HDL \_\_\_\_\_ LDL \_\_\_\_\_ Insulin \_\_\_\_\_ Glucose \_\_\_\_\_ BP \_\_\_\_\_

Please provide any additional pertinent information and provider notes.

Ordering Physician Signature: \_\_\_\_\_

Ordering Physician Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Referral Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_