



Pediatric Outpatient Registered Dietitian
2018 Clinch Ave, Knoxville, TN 37916
Phone: (865) 541-8512 • Fax: (865) 541-8681

Outpatient Nutrition Order

Patient's legal name: _____ Date: _____

Phone: _____ DOB: _____ Sex: Male Female

Address: _____

Father/mother: _____ Language patient speaks (if not English): _____

Primary insurance: _____ Secondary insurance: _____

Diagnosis: _____

Reason for medical nutrition therapy:

- Failure to thrive/weight loss
- Overweight/obesity
- 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 _____

When faxing referrals:

Please include additional pertinent information and provider notes.

Ordering physician signature: _____

Ordering physician print name: _____

Address: _____

Referral contact: _____

Phone: _____ Fax: _____