Nutrition Education Referral PHYSICIAN ORDER



Please COMPLETE ALL INFORMATION BELOW. FAX this form AND insurance authorization to Centralized Scheduling

Patient's Name		Patient's typ	Patient's type of insurance		
DOB			Is authoriza	tion required?	
			Yes No	Yes No	
Phone (Home)	Phon	Phone (Work/Mobile)		If yes, provide authorization number.	
Patient's primary	//preferred language:		# of referra	ls authorized:	
English	Spanish Other:				
NUTRITION COUNS	SELING TREATMENT	LOCATION			
	-Management Training (DSMT) tion Therapy (MNT)	4101 Torran Providence	ce Blvd., Torrance, CA 9	Medical Center San Pedro	
ICD 10-CM CODE (D	IAGNOSIS):	1300 ₩ 71113	31, 3411 Feuro, 6A 30/32	Fax. 055-355-0330	
LABS					
Glucose	HbA1c	Chol	LDL	Trig	
NA	K	BUN	Creatinine	Phos	
PERTINENT MEDIC	CATIONS:	COMPLICATIONS/CO	-MORBIDITIES (CHECK A	ALL THAT APPLY):	
		Change in treatr Stroke Retinopathy Renal Disease PCOS Hypertension CHF	ment Celiac Disease Nephropathy Pregnancy & Diabetes Dyslipidemia CHD	Hypoglycemia Non-healing wound PVD Neuropathy Obesity	
				QUESTIONS? Call Centralized Scheduling: San Pedro - 855-353-3940	
Referring Physician's Name (Print Clearly)				Torrance - 310-303-6500 OFFICE HOURS	
Physician's Signat	ure			Monday - Friday: 8am - 5pm	
 Date	Time			PLCM TORRANCE TAX ID# 21672810, NPI # 1902844988	
				PLCM SAN PEDRO TAX ID# 421672806, NPI# 1942247291	
Office Phone		Office Fax		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	