EAST TENNESSEE Children's Hospital

Pediatric Outpatient Registered Dietitian
2018 Clinch Ave, Knoxville, TN 37916
Phone: (865) 541-8755 • Fax: (865) 541-8681

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: _____