Verity Nutrition

Pediatric Medical Nutrition Therapy — Provider Referral Form

To be completed by the referring provider and returned by secure fax. Please attach relevant growth charts, labs, or clinic notes if available.

PLEASE FAX COMPLETED FORM TO: (937) 630 – 3922

Questions about a referral? Call (937) 479-2692 or email admin@veritynutritionco.com

REFERRING PROVIDER INFORMATION

Provider Name: _____ **NPI #:** _____

Practice / Clinic: _____ **Specialty:** _____

Practice Phone: _____ **Practice Fax:** _____

Practice Address: _____

Date of Referral: _____

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____

Parent / Guardian: _____ **Relationship:** _____

Parent Phone: _____ **Parent Email:** _____

Mailing Address: _____

INSURANCE INFORMATION

Insurance Carrier: _____

Member ID #: _____ **Group #:** _____

Policyholder Name: _____ **Policyholder DOB:** _____

Secondary Insurance (if any): _____

REASON FOR REFERRAL

ICD-10 codes shown are common examples — please confirm or update with the code that reflects your clinical assessment.

- ☐ Failure to thrive / poor weight gain (R62.51)
- ☐ Overweight / rapid weight gain (E66.3 / R63.5)
- ☐ Picky eating / food selectivity (R63.30)
- ☐ Pediatric feeding disorder, acute or chronic (R63.31 / R63.32)
- ☐ Tube weaning / transition (Z43.1)
- ☐ Oral aversion (F98.29)
- ☐ GI concerns — reflux, constipation, etc. (K21.9 / K59.00)
- ☐ Food allergy / intolerance (T78.1XXA)
- ☐ Prematurity / NICU graduate (P07.3-)
- ☐ Failure to establish breast/bottle feeding (P92.5)
- ☐ Prenatal or maternal nutrition (Z71.3)
- ☐ Postpartum / lactation-related nutrition (O92.79)
- ☐ Other (describe below):

ADDITIONAL INFORMATION

Please attach chart notes, growth charts, labs, and any other relevant clinical data along with this referral.

AUTHORIZATION & SIGNATURE

I am referring this patient/family for pediatric medical nutrition therapy and authorize Verity Nutrition Co. to contact the patient's parent/guardian directly to schedule services. I authorize the release of the information above, and any attached records, to Verity Nutrition Co. for the purpose of coordinating this patient's nutrition care.

Provider Signature: _____ **Date:** _____

Printed Name: _____