PRINT BLANK FORM | PRINT COMPLETED FORM AND RESET | RESET FORM

Patient Phone #:_______________________________ Medicare # (if applicable):____________________

DOB:____________________ Age: ____________________

Adult Scheduling Appointments:

Fax completed Referral form to appropriate clinic, and Call Scheduling Line to schedule appointment

For questions: Contact the Adult RD on call by paging operator 843-792-2123

ADULT CLINICS:	Scheduling Line:	Fax:
☐ General Adult (Rutledge)	843-876-0888	843-792-2995
☐ Hollings Cancer Center (HCC)	843-792-9300	843-792-1190
☐ Cardiology (Seinsheimer)	943-792-1952	843-876-4990
☐ Prenatal Wellness	843-876-1200	843-876-1264
☐ GI Medicine	843-792-6901	843-876-4717

Reasons for Referral *(Check the most appropriate diagnosis)*

- ☐ **E10._ Type 1 Diabetes**
- ☐ **E10.8 Type 1 Diabetes with unspecified complications**
- ☐ **E10.9 Type 1 Diabetes without complications**
- ☐ **E11._ Type 2 Diabetes**
- ☐ **E11.8 Type 2 Diabetes with unspecified complications**
- ☐ **E11.9 Type 2 Diabetes without complications**
- ☐ **O24.01 Pre-existing diabetes , type 1 in pregnancy**
- ☐ **O24.11 Pre-existing diabetes, type 2 in pregnancy**
- ☐ **O24.410 Gestational diabetes, diet controlled**
- ☐ **O24.414 Gestational diabetes, insulin controlled**
- ☐ **N18.5 Chronic kidney disease, stage 5**
- ☐ **N18.4 Chronic kidney disease, stage 4**
- ☐ **N18.3 Chronic kidney disease, stage 3**
- ☐ **N18.2 Chronic kidney disease, stage 2**
- ☐ **N18.1 Chronic kidney disease, stage 1**
- ☐ **Z94.0 Kidney transplant status**
- ☐ **K31.8 Gastroparesis**
- ☐ **E66.3 Overweight**
- ☐ **EGG.9 Obesity, unspecified**
- ☐ **R63.5 Abnormal weight gain**
- ☐ **R63.4 Abnormal weight loss**
- ☐ **R63.6 Underweight**
- ☐ **I10 Essential hypertension**
- ☐ **I50 Heart Failure**
- ☐ **E78.5 Hyperlipidemia, unspecified**
- ☐ **E88.81 Metabolic Syndrome**
- ☐ **E78.0 Hypercholesterolemia**
- ☐ **K50.9 Crohn's Disease**
- ☐ **K90.90 Celiac Disease**
- ☐ **K58 Irritable Bowel Disease**
- ☐ **K51 Ulcerative colitis**
- ☐ **E16.2 Hypoglycemia, unspecified**
- ☐ **Z68.__ BMI (specifiy range __ (adult)**

Other Diagnosis:

If not listed above (must check clinic box)________________________________ICD 10 ______________

(Please list other relevant medical conditions or attach most recent progress note)

Labs: *(most recent)*

Date	Lab
	BP:
	Glucose:
	HbA1C:
	Total cholesterol:
	HDL:
	LDL:
	Triglycerides:

Print Physician Name:________________________________ UPIN / NPI :________________

Physician Signature:________________________________ Date: ________________

Physician Phone #:____________________ Pager ID:____________ Fax: ________________