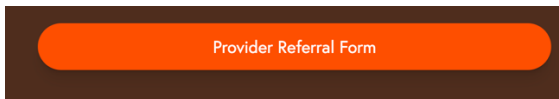
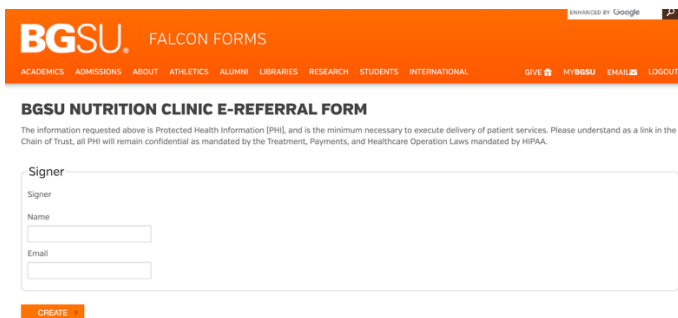


## How to refer?

1. Complete the online referral. Available at [www.bgsu.edu/nutritionclinic](http://www.bgsu.edu/nutritionclinic) or at [www.bgsu.edu/dpp](http://www.bgsu.edu/dpp).
  - a. Click the “Provider Referral Form” button



- b. Next you will need to fill in the name for the form and the email (i.e., staff email, clinic email) where the form will be sent to. You can enter the staff or provider name in the “Signer” name field. Note: the name you enter will auto-populate into the prepared form for the client/patient information. You will need to update this later in the actual form to the client’s name.

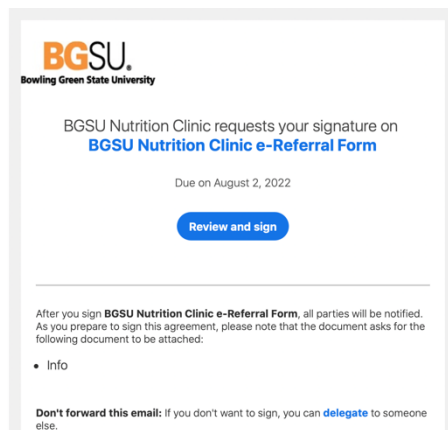


- c. Check email for the Adobe Sign notification. Open the email and complete the form. Once the form is completed it will be routed to the nutrition clinic’s secure access.

### **NEXT STEP - CHECK YOUR EMAIL TO SIGN YOUR AGREEMENT**

Your agreement is being created and will be sent to your email shortly (from BGSU's Adobe e-signature address, [adobesign@adobesign.com](mailto:adobesign@adobesign.com)). Once received, please click the "Review and Sign" button.

- d. From your email click “Review and Sign” from the email. You may need to enter your email credentials to access the Adobe Sign form.



- e. Complete the required form fields. Start with updating first and last name.

- f. Complete the referral needs section.  
g. Indicate the service(s) requested. You can select more than one option for the referral.

**REFERRAL NEEDS**

New Diagnosis  New Treatment Plan  New Complication

Special Needs:  Vision  Speech  Hearing  Cognitive  Other ( \_\_\_\_\_ )

ICD-10 Code	ICD-10 Description

[Nutrition related ICD-10 Codes are listed on our website](#)

**SERVICES REQUESTED**

Nutrition Education (*general healthy diet, basic nutrition education*)

Medical Nutrition Therapy (*individualized nutrition counseling as a necessary part of medical treatment and prevention of complications for diagnoses listed on this referral*)  
 \_\_\_\_\_ number of sessions or \_\_\_\_\_ BGSU Nutrition Clinic to determine

Virtual Diabetes Prevention Program (DPP)  
 Patient meet the [DPP eligibility criteria](#)? \_\_\_ Yes \_\_\_ No  
[Pre-Diabetes Screening Test Result](#): \_\_\_\_\_ points  
**Note: A FBS result OR 2-hr glucose OR a recent A1c is required for referral to the DPP**

- h. If your client is being referred for the diabetes prevention program, we ask that you confirm eligibility and that you assess risk by completing the pre-diabetes screening. Report the score on the form. Please attach any relevant labs, or history of medications.

**CLIENT/PATIENT DATA**

Physical activity release (may do moderate physical activity 20-30 minutes 5-7x/week)  
 Not released for physical activity

Height \_\_\_\_\_ (inches) Weight \_\_\_\_\_ (pounds) A1c \_\_\_\_\_ FBS \_\_\_\_\_ 2-hr glucose \_\_\_\_\_  
 Tot.Chol \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_ Trigs \_\_\_\_\_ GFR \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

Medication/Supplement Use: \_\_\_\_\_

**PROVIDER INFO.**

Clinic Name: \_\_\_\_\_ Clinic Email: \_\_\_\_\_ Please attach additional labs/info: [Click to Attach...](#)

\_\_\_\_\_  
 \* [Click here to sign](#) \_\_\_\_\_ 06/03/2022

Referring Provider Name      Provider Signature or MD/DO Co-Signature      Date

- i. If you have any questions, please contact us at [nutritionclinic@bgsu.edu](mailto:nutritionclinic@bgsu.edu). If all else fails, we can coordinate a faxed referral. You can download a copy of the PDF form from our website and fax the completed form to The Nutrition Clinic, Attention Kerri Knippen at 419-372-2881.

**BGSU Nutrition Clinic e-Referral Form**

**CLIENT/PATIENT INFO.**

First and Last Name:

Phone (with area code):

Email:

Birth Month and Birth Year:

**REFERRAL NEEDS**

New Diagnosis  New Treatment Plan  New Complication

**Special Needs:**  Vision  Speech  Hearing  Cognitive  Other (\_\_\_\_\_)

ICD-10 Code	ICD-10 Description

[Nutrition related ICD-10 Codes are listed on our website](#)

**SERVICES REQUESTED**

Nutrition Education (*general healthy diet, basic nutrition education*)

Medical Nutrition Therapy (*individualized nutrition counseling as a necessary part of medical treatment and prevention of complications for diagnoses listed on this referral*)

\_\_\_\_\_ number of sessions or \_\_\_\_\_ BGSU Nutrition Clinic to determine

Virtual Diabetes Prevention Program (DPP)

Patient meet the [DPP eligibility criteria](#)? \_\_\_\_\_ Yes \_\_\_\_\_ No

[Pre-Diabetes Screening Test Result](#): \_\_\_\_\_ points

**Note: A FBS result OR 2-hr glucose OR a recent A1c is required for referral to the DPP**

**CLIENT/PATIENT DATA**

Physical activity release (may do moderate physical activity 20-30 minutes 5-7x/week)

Not released for physical activity

Height \_\_\_\_\_ (inches) Weight \_\_\_\_\_ (pounds) A1c \_\_\_\_\_ FBS \_\_\_\_\_ 2-hr glucose \_\_\_\_\_

Tot.Chol \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_ Trigs \_\_\_\_\_ GFR \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

**Medication/Supplement Use:**

**PROVIDER INFO.**

Clinic Name:

Clinic Email:

Please attach additional labs/info:

Referring Provider Name

Provider Signature or MD/DO Co-Signature

Date

*\*MNT must be ordered/co-signed by MD or DO (to delegate to an overseeing physician, please click "Alternative Actions" and you can then enter email address and message for the delegated signer)*