

**Nutrition Referral**

**Child's Name Date \_\_\_\_**

**Child's Weight \_ Height \_\_\_ BMI Percentage \_\_\_\_**

**Teacher/CFS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian’s Name**

**Mailing Address \_\_\_\_**

**City & ZIP \_\_\_\_\_**

**Phone ( ) Best Time to Call: am/pm\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Area(s) of Concern: (check all that apply)**

|  |  |  |
| --- | --- | --- |
| **\_\_\_\_Pale Complexion**  | **\_\_\_\_Dental Disease** | **\_\_\_\_Low Hematocrit**  |
| **\_\_\_\_Overweight** | **\_\_\_\_Underweight** | **\_\_\_\_Low Energy** |
| **\_\_\_\_Food Allergy (Specify)** | **\_\_\_\_Food Dislike (Specify)** | **\_\_\_\_Other (Specify)** |

**Please share background information regarding this referral**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Referred by:** |  |  |
| **\_\_\_\_Parent/Guardian** | **\_\_\_\_Medical Professional** | **\_\_\_\_Staff** |

|  |  |  |
| --- | --- | --- |
| **Request:** **\_\_\_\_One on One Conference** | **\_\_\_\_Mailed Information** | **­­­****\_\_\_\_Telephone Conference** |

**I, , understand the nature of this referral and agree to the above request.**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5/23 Distribution: e-mail** **atemple@nmcaa.net****; Copy: Child's File (L#26) Health Manager: Upload to ChildPlus**

**EHS-HS Teams\ADMIN\Procedure Manual\Health\Nutrition Referral**