VSH | VETERINARY SPECIALTY HOSPITAL of the Carolinas

Phone: (919) 233-4911
Fax: (919) 882-8809
Email: nutrition.vshcarolinas@bluepearlvet.com

Clinical Nutrition Service Referral Form

REFERRING CLINICIAN INFORMATION

Dr. ______________________________ **from** ____________________________________
First and Last Name — Hospital/ Clinic

Address:____
Street Name and Number

____
City — State — Zip Code

Phone: ____________________________ **Fax:** ___________________________________

Clinician Email: ____

Service(s) Desired	Delivered
☐ Courtesy commercial recommendations	To referring clinician ONLY
☐ Commercial diet recommendations	To referring clinician and client
☐ Weight Loss Plan	To referring clinician and client
☐ Assisted (tube) feeding recommendations	To referring clinician
Tube type and size:_________________________ (ex: 19 French, E tube)	
☐ New homemade diet formulation	To referring clinician and client
☐ New homemade diet formulation (after 2, additional recipes available at a discount)	To referring clinician and client
☐ New homemade diet and commercial diet	To referring clinician and client
☐ Homemade diet analysis (does not include correction to a complete and balanced diet)	To referring clinician and client
☐ Homemade diet analysis and reformulation	To referring clinician and client

Who should be billed for the selected services? ☐ Hospital ☐ Client

****Exception, all assisted feeding consultations are billed to requesting hospital.**

If billing the hospital: Once the client is contacted, may we proceed with the consultation?
☐ No, please contact the hospital first ☐ Yes, please proceed with consultation

Please note, for all consultation types the client will be contacted and communicated with directly. If possible, please let the client know to expect a call/ email from us.

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CLIENT AND PATIENT INFORMATION

Client Name: ____

Title (Mr/Ms/ Dr) First Last

Address: ____

Street Name and Number

____

City State Zip Code

Phone: ______________________

Email: ______________________

Pet's Name: ______________________

Breed: ______________________

Pet's age/ birth date: ______________________

Canine ☐ Feline ☐ Other ☐

F ☐ FS ☐ M ☐ MC ☐

Body Weight__________ kg ☐ lbs ☐

Body Condition _____ / 9

1= thin, 5= ideal, 9= obese

Muscle Mass 3 ☐ 2 ☐ 1 ☐ 0 ☐

Normal, Mild Atrophy, Moderate Atrophy, Severe Atrophy

Current and past pertinent medical history *** Please use an additional page if needed**

1. Example: CKD, IRIS Stage 3 (normotensive, proteinuric)
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________
11. ______________________
12. ______________________
13. ______________________
14. ______________________
15. ______________________
16. ______________________
17. ______________________
18. ______________________
19. ______________________
20. ______________________

Current medications/ supplements, dose, frequency *** Please use an additional page if needed**

1. Example: Fish oil, 980mg EPA+ DHA, q24 hr.
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

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Clinical Nutrition Service Referral Form

Current appetite: ☐ **normal** ☐ **hyporexic** (66-99%) ☐**anorexic** (< 66%)

hyporexic: __________ Number
anorexic: __________ Number

Have there been any unintended changes in body weight?

☐ **No**

☐ **Yes – gained** ______ (#) ☐ kgs / ☐ lbs over ______ (#) ☐ weeks / ☐ months

☐ **Yes – lost** ______ (#) ☐ kgs / ☐ lbs over ______ (#) ☐ weeks / ☐ months

Vomiting? ☐ **No** ☐ **Yes,** for ______ (#) ☐ weeks / ☐ months / ☐ years

If yes, please describe frequency, predisposing factors (if known), treatments provided and response:

____

____

Regurgitation? ☐ **No** ☐ **Yes,** for ______ (#) ☐ weeks / ☐ months / ☐ years

If yes, please describe frequency, predisposing factors (if known), treatments provided and response:

____

____

Diarrhea? ☐ **No** ☐ **Yes,** for ______ (#) ☐ weeks / ☐ months / ☐ years

If yes, please describe frequency, predisposing factors (if known), treatments provided and response:

____

____

Additional Notes:

*****Please send all pertinent medical records (for the last year) AND all diagnostics results (for the last 3 years) to the VSH Clinical Nutrition Service.*****

Thank you for entrusting us with your patients' care! We would be delighted to help in any way possible. Please fill out this form completely and return by email to
nutrition.vshcarolinas@bluepearlvet.com or by fax to 919-882-8809. We look forward to working with you!