



To schedule an appointment please call
Kim Neally at 410-955-7139
Fax: 410-614-9586

THE JOHNS HOPKINS COMPREHENSIVE DIABETES CENTER NUTRITION CONSULT FORM

Referral Date: _____

Dietitian: Emily Loghmani MS, RD, LDN, CDE

When Needed?
 A.S.A.P < 2 Weeks; >1-2 Months

Referral Source:
 Dr. Saudek Dr. Clark Dr. Golden Dr. Brown
 Nancyellen Brennan FNP, CDE Other: _____

To be completed by referral source:

Primary Problem:

Age: _____ yo. ♂ OR ♀

type 1 DM type 2 DM

Other relevant co-morbidities: _____

Education Needs:

<input type="checkbox"/> carbohydrate controlled diet	<input type="checkbox"/> CHO Awareness	<input type="checkbox"/> CHO Counting
<input type="checkbox"/> CHO counting refresher	<input type="checkbox"/> cholesterol lowering	<input type="checkbox"/> triglyceride lowering
<input type="checkbox"/> mildly hypocaloric diet / wt. loss	<input type="checkbox"/> exercise	<input type="checkbox"/> significantly hypocaloric / wt loss
<input type="checkbox"/> renal diet	<input type="checkbox"/> low sodium diet	<input type="checkbox"/> meter training
<input type="checkbox"/> MNT for hyperglycemia	<input type="checkbox"/> MNT for hypoglycemia	<input type="checkbox"/> portion control
<input type="checkbox"/> other: _____		

(Signature)

(Print Signature)

(Pager #)