VSH VETERINARY SPECIALTY HOSPITAL of the Carolinas

Phone: (919) 233-4911
Fax: (919) 573-0792
Email: nutrition@vshcarolinas.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	Fee
☐ Courtesy commercial recommendations	To referring clinician ONLY	No charge
☐ Commercial diet recommendations	To referring clinician and client	$84
☐ Weight Loss Plan	To referring clinician and client	$126
☐ Assisted (tube) feeding recommendations	To referring clinician and client	$99
Tube type and size:_____ (ex: 19 French, E tube)		
☐ New homemade diet formulation	To referring clinician and client	$330
(additional recipes available for $80)		
☐ New homemade diet and commercial diet	To referring clinician and client	$405
☐ Homemade diet analysis	To referring clinician and client	$90
(does not include correction to a complete and balanced diet)		
☐ Homemade diet analysis and reformulation	To referring clinician and client	$405

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, 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 First Last

Address: _____
Street Name and Number

_____
City State Zip Code

Phone: ___(_____)_____

Email: _____

Pet's Name: _____

Breed: _____

Pet's age/ birth date: _____

Canine ☐ Feline ☐
F ☐ FS ☐ M ☐ MC ☐

Body Weight_____ kg ☐ lbs ☐

Body Condition _____ / 9
1= thin, 5= ideal, 9= obese

Muscle Mass 3 ☐ Normal 2 ☐ Mild Atrophy 1 ☐ Moderate Atrophy 0 ☐ Severe Atrophy

Current and past pertinent medical history

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

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

VSH VETERINARY SPECIALTY HOSPITAL of the Carolinas

Phone: (919) 600-6609
Fax: (919) 573-0792
Email: nutrition@vshcarolinas.com

Clinical Nutrition Service Referral Form

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

☐ for 1-5 days
☐ for > 5 days

☐ for 1-5 days
☐ for > 5 days

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 AND diagnostics results 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.com or by fax to 919-573-0792. We look forward to working with you!