



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

**THE JOHNS HOPKINS COMPREHENSIVE
DIABETES CENTER
NUTRITION CONSULT FORM**

Referral Date: _____
Dietitian: Michelle Bravo RD, LDN
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:

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

(Signature)

(Print Signature)

(Pager #)