Exhibit L2

# NUTRITION SCREENING REFERRAL FORM

## CLIENT INFORMATION

| | | | |
|---|---|---|---|
| **Client's Name:**<br><br>**Parent/Guardian Name** (if client is an infant)**:** | **Client's Date of Birth:** (mm/dd/yyyy)<br><br>**Social Security #**<br><br>**Medicaid #** | ☐ **Pregnant**<br>☐ **Post-partum** (8 weeks)<br>☐ **Infant** (0-1 year)<br>☐ **Child** (1-3 years)<br>☐ **1st Time Mom** | **Home Phone**<br>**(  )**<br><br>**Cell Phone**<br>**(  )** |
| **Street Address:** (street address, apartment#, city, state, zip code) ( P.O. Box is not acceptable.) | | | |

| | | | | |
|---|---|---|---|---|
| **Expected Date of Delivery:** | **Pre-pregnancy weight: _____**<br><br>**Present weight: _____** | **Height: _____ in (Calculated in inches)** | **Birth Weight: _____**<br><br>**Birth Length: _____** | **Language preferred:** |

| UNDERWEIGHT | NORMAL | OVERWEIGHT | OBESE | EXTREME OBESE | Client's BMI |
|---|---|---|---|---|---|
| < 19 | 19 – 24 | 25 – 29 | 30 – 39 | ≥ 40 | |

## PROVIDER INFORMATION

| | | |
|---|---|---|
| **Referred To:** | **Address:** | **Phone:**<br><br>**Fax:** |
| **From:** (name of person making referral) | **Title:** | |
| **Organization:** | **Address:** | **Work Phone:**<br><br>**Cell Phone:** |

☐ **Client is expecting twins.** ☐ **Other _____**

☐ **Client has been smoking three (3) months prior to being pregnant.**

☐ **Client is currently smoking.**

☐ **Client has been drinking alcoholic beverages three (3) months prior to being pregnant.**

☐ **Client is currently drinking.**

☐ **Client has known food allergies: _____**

☐ **Client has family history of:** ☐ **Diabetes Mellitus** ☐ **High Blood Pressure** ☐ **None**

**Best time to contact client:_____**

**Risk Level:_____**

**OB/GYN or Pediatrician:**

**Client has been diagnosed with:** (check all that apply)

| | | | |
|---|---|---|---|
| ☐ **Anemia** | ☐ **Asthma** | ☐ **Depression** | ☐ **Thyroid disorder** |
| ☐ **Cancer** | ☐ **Celiac disease** | ☐ **Developmental delay** | ☐ **Infectious disease** |
| ☐ **Diabetes** | ☐ **Eating disorder** | ☐ **Gastrointestinal disorder** | ☐ **Nutrient deficiency disease** |
| ☐ **Gestational Diabetes** | ☐ **Hypertension** | ☐ **Hypoglycemia (low blood sugar)** | ☐ **Other: _____** |

☐ **Client has poor dietary habits. Specify: _____**

☐ **Client is taking prescribed medications. Reason: _____**

☐ **Client would like to have guidance in choosing a healthy diet for:** ☐ **Self** ☐ **Infant** ☐ **Child** **(This alone is not sufficient for referral.)**

☐ **Other:_____**

**Referring Person Signature _____** **Date_____**

**Response to Referral Originator:**

_____

**Respondent's Signature** **Date**