NC STATE UNIVERSITY

Referring Veterinarian Nutrition Consult Request

Veterinary Hospital
Phone: 919.513.6999
Fax: 919.513.6905
Email: NCStateVeterinaryNutrition@ncsu.edu

Date: _____ **Fee**

Referred for:

COMMERCIAL DIET REQUESTS

Options available:

☐ Optimal commercial diet options (To referring veterinarian)	No charge
☐ Commercial diet feeding recommendations (To owner)	$98
☐ Assisted (tube) feeding recommendations (To referring veterinarian)	$92

HOMEMADE DIET REQUESTS

Options available:

☐ Initial Consultation	$77
☐ Homemade diet formulation/evaluation	$342
☐ Homemade diet and commercial diet options	$425
☐ Homemade diet (minor) reformulation	$89

Homemade Diet Services done by in-hospital appointment only

One of our receptionists will call the owner to schedule an appointment with the Clinical Nutrition Service.

Referred by:

_____ of _____
Name Hospital

_____
Street Address

_____
City State Zip

_____ _____
Phone Fax

_____
Email

Patient/Client Information:

_____ DOB: _____ Age: _____
Pet Name

☐ Canine ☐ Feline
☐F ☐ F/S ☐ M ☐ M/C

_____ Body weight _____ ☐ kg ☐ lb Body Condition Score __ / 9
Breed

Muscle Condition Score ☐normal ☐mild atrophy
☐moderate atrophy ☐severe atrophy

_____
Client Name

_____
Street Address

_____
City State Zip

_____ _____
Phone Email

Summary of current and historical medical diagnoses: **PLEASE INCLUDE ALL PERTINENT MEDICAL RECORDS**

Example: IRIS stage 2 CKD – proteinuric, normotensive. Stable past 6 months. Tx amlodipine and enalapril.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Additional notes:

_____

_____

_____

Current Appetite: ☐ **Normal** | ☐ **Decreased by** ___ **25%** ___ **50%** ___ **75%** ☐ for 1-7 days ☐ for > 7 days | ☐ **Anorexic** ☐ for 1-7 days ☐ for > 7 days

Unintended change in body weight? ☐ **No**

☐ **Yes – gained** ____ ☐ kgs / ☐ lbs over ___ ☐ weeks / ☐ months

☐ **Yes – lost** ____ ☐ kgs / ☐ lbs over ___ ☐ weeks / ☐ months

History of gastrointestinal intolerance?

Please check all that apply

☐ **No**

☐ **Yes – vomiting** for ___ ☐ weeks / ☐ months / ☐ years

☐ **Yes – regurge** for ___ ☐ weeks / ☐ months / ☐ years

☐ **Yes – diarrhea** for ___ ☐ weeks / ☐ months / ☐ years

If checked yes, please describe frequency, identifiable predisposing factors, treatments provided and response.

_____

_____

_____

_____

Thank you for your referral. We appreciate the confidence you place in our service.

Please return form and pertinent medical records/ diagnostic results via:

Fax (919.513.6905) or Email (NCStateVeterinaryNutrition@ncsu.edu)

Revised 07.07.2020 JN