**DIAGNOSIS CODE FORM**

**ViTL Nutrition & Fitness**

19125 North Creek Parkway, Suite 142

Bothell, WA 98011

425.329.2659

contact@ViTLnutrition.com

**For PATIENT to complete:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** Click here to enter text. | | | |
| **Date of Birth:** Click here to enter text. | | **Phone:** Click here to enter text. | |
|  | | | |
| **\*Physician Name:** Click here to enter text. | | **\*Clinic Name:** Click here to enter text. | |
| **Address:** Click here to enter text. | | | |
| **Phone:** Click here to enter text. | **Fax:** Click here to enter text. | | **Email:** Click here to enter text. |

\*Physician Name and Clinic Name refer to the physician who has made the diagnosis.

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| --- |
| **Practitioner(s):**  Scott Littlefield, MS, CN, CISSN Susan Lewis, MS, CN |

**For PHYSICIAN to complete:**

|  |  |
| --- | --- |
| Diagnosis: Click here to enter te xt. | ICD-9: Click here to . |
| Diagnosis: Click here to enter te xt. | ICD-9: Click here to . |
| Diagnosis: Click here to enter te xt. | ICD-9: Click here to . |
| Diagnosis: Click here to enter te xt. | ICD-9: Click here to . |
| Comments: Click here to enter text. | |

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| --- | --- | --- | --- |
| **Physician’s Signature:** | Click here to enter text. | **Date:** | Click here t |