VERNON CANCER CENTER

DOCTOR'S ORDER

Medical Nutrition Therapy

Phone: 617-219-1230 (VCC support services)
Fax: 617-219-1243 (VCC support services)

Patient Name: ____**DOB**:______________

MR#: ___________________________

Primary Diagnosis (please specify)____

Diagnosis/Reason for Visit:

- ☐ Anemia
- ☐ Anorexia
- ☐ Bladder Cancer
- ☐ Breast cancer
- ☐ Cholangiocarcinoma
- ☐ Constipation
- ☐ Colorectal cancer
- ☐ Diarrhea
- ☐ Dry/sore mouth
- ☐ Dysgeusia
- ☐ Dysphagia
- ☐ Esophageal Cancer
- ☐ Food/Drug Interaction
- ☐ Gastric Cancer
- ☐ Gastroesophageal reflux
- ☐ Laryngeal Cancer
- ☐ Leukemia
- ☐ Liver Cancer
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Mucositis
- ☐ Nausea/vomiting
- ☐ Neutropenia
- ☐ Nutrition support recommendations (TPN/TF)
- ☐ Odynophagia
- ☐ Oral Cancer
- ☐ Pharyngeal Cancer
- ☐ Ovarian cancer
- ☐ Prostate Cancer
- ☐ Radiation enteritis
- ☐ Unintentional weight loss
- ☐ Uterine Cancer
- ☐ Dietary Surveillance (weight loss counseling)
- ☐ Other (please specify):____________________
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Referring MD:______________________________ **MD Phone #:**________________

MD signature: _____________________________________ **Date:** ________________