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Referral for Medical Nutrition Therapy (MNT)

Date:	Patient name:
Day time phone number:	Insurance: (Attach copy of front & back of card)
DOB:	Home address: Zip:

Above is referred for *medical nutrition therapy as a necessary part of medical treatment* and prevention of complications for diagnoses listed.

Referral Needs: ☐ New Diagnosis ☑ New treatment plan ☐ New complication

Special Needs: ☐ Language ☐ Hearing/Speech/Vision ☐ Learning/Processing

☐ Other:

✓ **Check all diagnoses that apply to this referral**

✓	ICD-10	ICD-10 Description	✓	ICD-10	ICD-10 Description
☐	E66.3	Overweight	☐	R73.01	Impaired Fasting Glucose
☐	E66.01	Morbid obesity d/t excess calories	☐	R73.03	Pre-Diabetes
☐	E66.811	Obesity Class I	☐	E11.69	Type 2 Diabetes w/ other complic.
☐	E66.812	Obesity Class II	☐	E11.8	Type 2 Diabetes w/ unspec.complic.
☐	E66.813	Obesity Class III	☐	E11.9	Type 2 Diabetes w/o complications
☐	E66.9	Obesity, unspecified	☐	Other:	
☐	Other:		☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐	I10	Essential (primary) Hypertensio	☐		
☐	E78.5	Hyperlipidemia, unspecified	☐		
☐	Z82.49	Family hx of ischemic disease	☐		
☐	Other:		☐		

✓ **Lab work** (Please attach or complete) BP ____/____

Hct/ Hgb	FBS &/or pc	Hgb A1c	Total Chol	HDL LDL	Non HDL	Trig	Ua Micro Albumin/Cr	BUN/ Cr	EGFR	Na/K	Phos/ PTH	Vit D

✓ **Exercise/Activity Plan**

☐ **Release:** may walk 20-30 min 5-7 x/week or _____

☐ **Not Released:** _____

✓ **Medications** – Please attach list

Physician signature X_____MD/DO Phone _____

NPI: _____ _____ Fax _____

Print MD/DO Name

The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.