

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: _____

<input checked="" type="checkbox"/> Check all diagnoses that apply to this referral					
<input checked="" type="checkbox"/>	ICD-10	ICD-10 Description	<input checked="" type="checkbox"/>	ICD-10	ICD-10 Description

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.