



Referral for Medical Nutrition Therapy (MNT)

Please attach list of current medications and lab results

Date:	Patient name:	DOB:
Daytime phone #:	Insurance:	Policy #:
Height:	Weight:	Gender:
Referral Needs: <input type="checkbox"/> Initial MNT <input type="checkbox"/> Follow-up MNT Hours of MNT requested <input type="checkbox"/> 3 hrs <input type="checkbox"/> 2 hrs _____ Other		
Special Needs: _____ Language _____ Hearing/Speech/Vision _____ Learning <input type="checkbox"/> N/A		

Reason for MNT Referral

Please complete the MNT referral form which includes the ICD-10 code(s) and physician signature.

ICD-10	Description	ICD-10	Description	ICD-10	Description
<input type="checkbox"/> E10.____	Type 1 diabetes mellitus	<input type="checkbox"/> K21.0	Gastroesophageal reflux disease with esophagitis	<input type="checkbox"/> D50.____	Iron deficiency anemia
<input type="checkbox"/> E11.____	Type 2 diabetes mellitus	<input type="checkbox"/> K21.9	Gastroesophageal reflux disease without esophagitis	<input type="checkbox"/> D51.3	Other dietary vitamin B12 deficiency anemia (vegan anemia)
<input type="checkbox"/> N18.____	Chronic kidney disease	<input type="checkbox"/> K25	Gastric ulcer	<input type="checkbox"/> D52.0	Dietary folate anemia
<input type="checkbox"/> E66.____	Overweight / Obesity	<input type="checkbox"/> K27	Peptic ulcer, site unspecified	<input type="checkbox"/> D53.____	Deficiency anemia
<input type="checkbox"/> E63.____	Abnormal weight loss/gain/underweight	<input type="checkbox"/> K29.____	Gastritis	<input type="checkbox"/> M81.____	Osteoporosis
<input type="checkbox"/> Z68.____	BMI < 19 or BMI > 30 (adult)	<input type="checkbox"/> K50.____	Crohn's disease	<input type="checkbox"/> G47.3__	Sleep apnea
<input type="checkbox"/> Z71.3	Dietary counseling and surveillance	<input type="checkbox"/> K51	Ulcerative colitis	<input type="checkbox"/> R73.01	Impaired fasting glucose
<input type="checkbox"/> I10	Essential (primary) hypertension	<input type="checkbox"/> K57.____	Diverticulosis	<input type="checkbox"/> R73.02	Impaired glucose tolerance test (oral)
<input type="checkbox"/> I11.0	Hypertensive heart disease with (congestive) heart failure	<input type="checkbox"/> K58	Irritable bowel syndrome	<input type="checkbox"/> R73.03	Pre-diabetes
<input type="checkbox"/> I11.9	Hypertensive heart disease without (congestive) heart failure	<input type="checkbox"/> K59	Constipation	<input type="checkbox"/> E43	Unspecified severe protein-calorie malnutrition
<input type="checkbox"/> I12	Hypertensive chronic kidney disease	<input type="checkbox"/> O21.____	Hyperemesis gravidarum	<input type="checkbox"/> E44.____	Mild-moderate protein-calorie malnutrition
<input type="checkbox"/> I25	Chronic ischemic heart disease	<input type="checkbox"/> O24.____	Gestational diabetes mellitus	<input type="checkbox"/> E46	Unspecified protein-calorie malnutrition
<input type="checkbox"/> I50	Heart failure	<input type="checkbox"/> O26.____	Excessive/low weight gain during pregnancy	Other	
<input type="checkbox"/> E78.0	Pure hypercholesterolemia	<input type="checkbox"/> E03.9	Hypothyroidism, unspecified	<input type="checkbox"/> _____	_____
<input type="checkbox"/> E78.1	Pure hyperglyceridemia	<input type="checkbox"/> E16.____	Hypoglycemia	<input type="checkbox"/> _____	_____
<input type="checkbox"/> E78.2	Mixed hyperlipidemia	<input type="checkbox"/> E73.____	Endocrine, nutritional, & metabolic diseases	<input type="checkbox"/> _____	_____
<input type="checkbox"/> E78.5	Hyperlipidemia, unspecified	<input type="checkbox"/> M1A.____	Chronic gout	<input type="checkbox"/> _____	_____
<input type="checkbox"/> E88.81	Metabolic syndrome	<input type="checkbox"/> M10.____	Gout, other causes	<input type="checkbox"/> _____	_____
<input type="checkbox"/> F50.____	Mental and behavioral disorders	<input type="checkbox"/> B20	HIV disease	<input type="checkbox"/> _____	_____

Exercise/Activity Plan:

- Release, _____ min/day OR _____ min/week
 Not Released

Comments: _____

Physician's Signature _____ Date _____

Physician's Name (Printed) _____

NPI #: _____

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

Relevant Lab Data or attach current labs

Date	Lab Value
	BP: _____ mmHg
	Gluc: _____ mg/dL
	HbA1c: _____ %
	TC: _____ mg/dL
	HDL: _____ mg/dL
	LDL: _____ mg/dL
	TG: _____ g/dL
	BUN: _____ mg/dL
	ALB: _____ g/dL
	Creat: _____ mg/dL