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

✓ **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.