**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.

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| --- | --- | --- | --- |
| **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** |
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 **Demographics** (Please attach or complete)

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| --- | --- |
| HT |  |
| WT |  |
| BMI |  |

 **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:

Print MD/DO Name

Fax

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.