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Referral for Medical Nutrition Therapy (MNT)

Date:	Patient name:
DOB	Home address
Day time phone number:	Email:

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
	E10....	Type 1 DM		I10	Hypertension, essential
	E10.9	Type 1 DM w/o cx		E78.5	Hyperlipidemia, unspecified
	E11...	Type 2 DM		I50	Congestive Heart Failure
	E11.6	Type 2 DM w/o cx		E66.01	Morbid obesity
	O24.410	Gestational DM diet controlled		E66.0	Obesity
				G47.33	Obstructive sleep apnea
	R73.01	Impaired Glucose Tolerance		G47.30	Sleep apnea, unspecified
	E88.81	Metabolic Syndrome		R63.4	Abnormal Weight Loss
	E28.2	Polycystic Ovary Syndrome		K90.0	Celiac Disease
	N18.5	CKD, Stage 5		K52.2	Allergic and dietetic gastroenteritis and colitis
	N18.3	CKD, Stage 3 (GFR 30-59)		Z71.3	Dietary Surveillance and counseling
	N18.4	CKD, Stage 4 (GFR 15-29)			
	NA	WELLNESS/HEALTH COACHING			

✓ **Lab work** (Please attach)

✓ **Exercise/Activity Plan**

□ **Release:** list any restrictions_____

□ **Not Released:** _____

✓ **Medications** – Please attach list

Physician signature X_____MD/DO Phone _____

NPI: _____ _____ Fax _____

Print MD/DO Name