

**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.				
F50.00	Anorexia nervosa, unspecified		R73.03	Prediabetes
F50.019	AN, restricting type, unspecified		R73.01	Impaired fasting glucose
F50.029	AN, binge eating/purging type, unspecified		E11.8	Type 2 diabetes mellitus
F50.20	Bulimia nervosa		E10.8	Type 1 diabetes mellitus
F50.819	Binge eating disorder			Gastrointestinal disease (please specify ICD-10)
F50.9	Eating disorder, unspecified			
R62.51	Failure to thrive (child)		E78.0-E78.3	Cardiovascular disease/or risk of
R63.4	Abnormal weight loss		I10	Essential (primary) hypertension
R63.5	Abnormal weight gain - not during pregnancy		E78.5	Hyperlipidemia, unspecified
R63.6	Underweight		I25	Cornary artery disease
E28.2	Polycystic Ovary Syndrome (PCOS)		J44.9	COPD
E66.9	Obesity			Liver disease (please specify ICD-10)
E66.3	Overweight			Seizures (please specify ICD-10)
				Pre-end stage renal and/or CKD (please specify ICD-10)

✓ Lab work (please attach or complete)

Hct/Hgb	FBG	HgBA1c	Total Chol	HDL	LDL	Heart Rate	Trig	EGFR	TSH/T4

BUN/Cr	Na/K	Phos/PTH	wBC	Iron	Ferritin

BP \_\_\_\_ / \_\_\_\_

✓ Exercise/Activity Plan

Release: \_\_\_\_\_  
 Not Released: \_\_\_\_\_

Provider signature: \_\_\_\_\_ NPI \_\_\_\_\_ FAX \_\_\_\_\_  
 Print Name \_\_\_\_\_ Phone \_\_\_\_\_