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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 or enter appropriate diagnoses in spaces provided**

✓	ICD-10	ICD-10 Description	✓	ICD-10	ICD-10 Description
☐	N18.____	Chronic kidney disease	☐	F50.00	Anorexia nervosa, unspecified
☐			☐	F50.01	Anorexia nervosa, restricting type
☐	N18.3	Chronic kidney disease, stage 3	☐	F50.02	Anorexia nervosa, binge eating/purging type
☐	N18.4	Chronic kidney disease, stage 4	☐	F50.2	Bulimia nervosa
☐	Z48.22	Encounter for aftercare following kidney transplant	☐	F50.8	Other eating disorder
☐			☐	F50.9	Eating disorder, unspecified
☐	E10.____	Type I diabetes mellitus	☐		
☐			☐		
☐	E10.9	Type I diabetes mellitus without complications	☐		
☐			☐		
☐	E11.____	Type II diabetes mellitus	☐		
☐			☐		
☐	E11.9	Type II diabetes mellitus without complications	☐		
☐			☐		
☐			☐		

✓ **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_____ Phone _____

NPI: _____ _____ Fax _____

Print Physician 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.