CHRISTINE CRAIG

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REFERRAL FOR MEDICAL NUTRITION THERAPY (MNT)

PATIENT NAME: **DATE:**

PHONE NUMBER: **DOB:**

HOME ADDRESS: **EMAIL:**

Above is referred for MNT as a necessary part of medical treatment and prevention of complications for diagnosis 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	DESCRIPTION	ICD-10	DESCRIPTION
☐ E11.8	Type 2 diabetes mellitus with unspecified complications	☐ E28.2	Polycystic Ovarian Syndrome
☐ E11.9	Type 2 diabetes mellitus without complications	☐ K90.0	Celiac Disease
☐ E11._	Type 2 diabetes mellitus	☐ E88.81	Metabolic syndrome
☐ E10.8	Type 1 diabetes mellitus with unspecified complications	☐ E66.3	Overweight
☐ E10.9	Type 1 diabetes mellitus without complications	☐ E66.9	Obesity, unspecified - obesity NOS
☐ E10._	Type 1 diabetes mellitus	☐ R3.6	Underweight
☐ I10	Essential (primary) hypertension	☐ Z71.3	Dietary counseling and surveillance
☐ E78.5	Hyperlipidemia, unspecified	☐	(other, specify)
☐ E	(other, specify)	☐	(other, specify)

✓ **Lab Work (Please Attach or Complete)** **BP**_____/______

Hct/ Hgb	FBS &/or pc	Hgb Alc	Total Chol	HDL LDL	Non HDL	Trig	Ua Micro Albumin/Cr	BUN/ Cr	EGFR	Na/K	Phos/ PTH	Vit D

✓ Exercise/Activity Plan
☐ Released ☐ Not Released ☐Restrictions: ____________________

✓ Medications – Please Attach List

HCP Signature: **X** ____________________ Phone: ____________________

Print Name: ______________ NPI: ______________ Fax: ______________

Please FAX referral to (530) 267-8313