Nutrition for Daily Living
Nutrition for YOUR Health, Nutrition for YOUR Life

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Referral for Medical Nutrition Therapy (MNT)

Date:	Patient name:
Phone number:	E-mail:
DOB:	Home Address:

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	ICD-10 Description	✔	ICD-10	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	☐	R63.6	Underweight
☐	I10	Essential (primary) hypertension	☐	Z71.3	Dietary counseling and surveillance
☐	E78.5	Hyperlipidemia, unspecified	☐		(other, specify)
☐		(other, specify)	☐		(other, specify)

✔ **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**

☐ **Released** ☐ **Not Released** ☐ **Restrictions:**_____

✔ **Medications** – Please attach list

HCP Signature **X**_____ Phone _____

Print Name_____ NPI: _____ Fax _____

Please FAX referral to (530) 267-8313