

**Referral for Medical Nutrition Therapy**
*Please attach current list of medications, dosages & current lab results.*

Date:	Patient name:	Date of Birth:
Day time phone number:	Insurance:	Medical Record Number:
Height:	Weight:	Waist Circumference:
Requested service:		Gender:
Initial MNT	Follow-up MNT	Hours of MNT requested

<b>**REASON FOR ORDERING MNT**</b>				
<b>MEDICAL DIAGNOSES (check all that apply below)</b>				
<b>[Required in order to initiate MNT service]</b>				
ICD-10	ENDOCRINE, NUTRITIONAL AND METABOLIC, IMMUNITY		ICD-10	
E0800	Diabetes II/unspecified		I509	Heart Failure, unspecified
E109	Diabetes I, no complications			<b>DIGESTIVE SYSTEM</b>
E08638	Diabetes II/unspecified, uncontrolled		K50919	Crohn's disease unspecified, complications
E109	Diabetes I, unspecified complications		K51019	Ulcerative (chronic) enterocolitis, complications
E0810	Diabetes with ketoacidosis w/out coma		K5790	Diverticulosis of colon, part unspecified
E162	Hypoglycemia, unspecified		K5792	Diverticulitis of colon, part unspecified
E282	Polycystic ovarian syndrome		K580/K589	Irritable bowel syndrome, with/without diarrhea
E7439	Other disorders of carbohydrate absorption		K829	Unspecified disease of gallbladder
E749	Disorder of carbohydrate metabolism, unspecified			<b>GENITOURINARY SYSTEM</b>
E780	Pure hypercholesterolemia		N183	Chronic kidney disease, Stage III (moderate)
E781	Pure hyperglyceridemia		N184	Chronic kidney disease, Stage IV (severe)
E785	Hyperlipidemia, unspecified		N185	Chronic kidney disease, Stage V
E782	Mixed hyperlipidemia		N186	End stage renal disease
E756	Lipid storage disorder, unspecified		N189	Chronic kidney disease, unspecified
E8881	Metabolic syndrome			<b>SKIN AND SUBCUTANEOUS TISSUE</b>
E669	Obesity, unspecified		L272	Dermatitis: Due to Ingested Food
E6601	Morbid obesity			<b>SYMPTOMS, SIGNS, ILL-DEFINED</b>
E663	Overweight		R634	Abnormal weight loss
	<b>CIRCULATORY SYSTEM</b>		R635	Abnormal weight gain
I10	Essential hypertension		R7309	Abnormal glucose
I159	Secondary hypertension, unspecified			<b>OTHER</b>
I7090	Atherosclerosis, unspecified			

**Relevant Medications and Dosages (type/frequency):**
**Relevant Lab Data:**  
(attach current lab data)

Date:	Lab value:
	BP: mm Hg
	glucose: mg/dL
	HbA1c: %
	TC: mg/dL
	HDL: mg/dL
	LDL: mg/dL
	TG: g/dL
	BUN: mg/dL
	ALB: g/dL
	Creat: mg/dL

**Physical Activity Restrictions:** none: \_\_\_\_\_ limit to: \_\_\_\_\_

**Comments (medical conditions, goals for nutrition therapy):**
*MNT is a necessary part of the patient's medical treatment for the medical diagnosis (es) listed above.*
**Physician's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Physician's Name (Printed)** \_\_\_\_\_

**UPIN/NPI number:** \_\_\_\_\_

**Please fax to: 888-821-2292**