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Referral for Medical Nutrition Therapy (MNT)

Date:	Patient name:
Day time phone number:	Address:
DOB:	Email:

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**

✓	ICD-10	ICD-10 Description	✓	ICD-10	ICD-10 Description
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✓ **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_____MD/DO Phone _____

NPI: _____ _____ Fax _____

Print MD/DO 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.