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# Referral for Medical Nutrition Therapy (MNT)

| Date: | Patient name: |
|---|---|
| Day time phone number: | Insurance:<br>(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**

| ✓ | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
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✓ **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.