Medical Nutrition Therapy
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Medical Nutrition Therapy Referral Form

Patient Name:	DOB:
Address:	Phone:
Insurance:	Policy #:
Prior-Authorization # (if needed):	

Diagnosis/Reason for MNT Referral: ☑ Z71.3: Dietary counseling and surveillance

Additional MNT Diagnoses
(Please check all that apply and alter as needed)

□ Z68.__: Body Mass Index (BMI): _____, adult
□ E66.0 : Obese due to excess calories
□ E66.01: Morbid (severe) obesity due to excess calories
□ E66.3: Overweight
□ E66.8: Other Obesity
□ E66.9: Obesity, unspecified – Obesity NOS
□ R63.4: Abnormal weight loss
□ R63.5: Abnormal weight gain – not during pregnancy
□ R63.6: Underweight
□ K50.__: Crohn's Disease
□ E78.1: Pure hyperglyceridemia
□ E78.2: Mixed hyperlipidemia
□ E78.5: Hyperlipidemia, unspecified
□ E88.81: Metabolic syndrome
□ F50.__: Anorexia nervosa, _____
□ F50.2: Bulimia nervosa
□ F50.9: Eating disorder, unspecified
□ K51: Ulcerative colitis
□ _____ : _____

□ I11.___: Hypertensive heart disease_____
□ E10.___: Type 1 diabetes mellitus_____
□ E11.___: Type 2 diabetes mellitus_____
□ E16.1: Other hypoglycemia
□ E03.9: Hypothyroidism, unspecified
□ N18.___: Chronic Kidney Disease, _____
□ R73.03: Pre-diabetes
□ K57. ___: Diverticulosis _____
□ K21.___: Gastroesophageal reflux disease,_____
□ E78.0: Pure hypercholesterolemia
□ K58: Irritable bowel syndrome
□ K59: Constipation
□ K90.0: Celiac Disease
□ E28.2: Polycystic ovarian syndrome
□ O24.__ :Pre-existing diabetes mellitus type __, in pregnancy
□ O24.410: Gestational diabetes mellitus, diet-controlled
□ D50.8: Other iron deficiency anemias (d/t inadequate iron intake)
□ I10: Essential (primary) hypertension
□ _____ : _____

Please check any special needs (leave blank if none):

□ Physical □ Hearing □ Vision □ Cognitive □ Language Barrier □ Other:_____

Exercise:

□ Unrestricted □ Restricted: _____

Please also include:

- **Recent or related lab work**
- **Medication List**
- **Recent progress note or related office notes**

Physician's Printed Name (must be MD or DO):	Office Phone #:
	Office Fax #:
Physicians Signature:	Date: