Referral for Medical Nutrition Therapy (MNT)

Please attach list of current medications and lab results

Advanced Nutrition Services
nmrdn.com

Date:	Patient name:	DOB:
Daytime phone #:	Insurance:	Medical record #:
Height:	Weight:	Gender:
Referral Needs:	☐ Initial MNT ☐ Follow-up MNT Hours of MNT requested ☐ 3 hrs ☐ 2 hrs _____ Other	
Special Needs:	_____ Language _____ Hearing/Speech/Vision _____ Learning ☐ N/A	

Reason for MNT Referral

Please complete the MNT referral form which includes the ICD-10 code(s) and physician signature. Please indicate on the referral if the patient needs any special services. We also accept electronic referrals through our EMR platform, please call for details.

	ICD-10	Description
☐	E10.___	Type 1 diabetes mellitus
☐	E11.___	Type 2 diabetes mellitus
☐	N18.___	Chronic kidney disease
☐	E66. ___	Overweight / Obesity
☐	E63. ___	Abnormal weight loss/gain/underweight
☐	Z68.___	BMI < 19 or BMI > 30 (adult)
☐	Z71.3	Dietary counseling and surveillance
☐	I10	Essential (primary) hypertension
☐	I11.0	Hypertensive heart disease with (congestive) heart failure
☐	I11.9	Hypertensive heart disease without (congestive) heart failure
☐	I12	Hypertensive chronic kidney disease
☐	I25	Chronic ischemic heart disease
☐	I50	Heart failure
☐	E78.0	Pure hypercholesterolemia
☐	E78.1	Pure hyperglyceridemia
☐	E78.2	Mixed hyperlipidemia
☐	E78.5	Hyperlipidemia, unspecified
☐	E88.81	Metabolic syndrome
☐	F50.___	Mental and behavioral disorders

	ICD-10	Description
☐	K21.0	Gastroesophageal reflux disease with esophagitis
☐	K21.9	Gastroesophageal reflux disease without esophagitis
☐	K25	Gastric ulcer
☐	K27	Peptic ulcer, site unspecified
☐	K29.___	Gastritis
☐	K50.___	Crohn's disease
☐	K51	Ulcerative colitis
☐	K57.___	Diverticulosis
☐	K58	Irritable bowel syndrome
☐	K59	Constipation
☐	O21.___	Hyperemesis gravidarum
☐	O24.___	Gestational diabetes mellitus
☐	O26.___	Excessive/low weight gain during pregnancy
☐	E03.9	Hypothyroidism, unspecified
☐	E16.___	Hypoglycemia
☐	E73.___	Endocrine, nutritional, & metabolic diseases
☐	M1A.__	Chronic gout
☐	M10.___	Gout, other causes
☐	B20	HIV disease

	ICD-10	Description
☐	D50.___	Iron deficiency anemia
☐	D51.3	Other dietary vitamin B12 deficiency anemia (vegan anemia)
☐	D52.0	Dietary folate anemia
☐	D53.___	Deficiency anemia
☐	M81.___	Osteoporosis
☐	G47.3__	Sleep apnea
☐	R73.01	Impaired fasting glucose
☐	R73.02	Impaired glucose tolerance test (oral)
☐	R73.03	Pre-diabetes
☐	E43	Unspecified severe protein-calorie malnutrition
☐	E44.___	Mild-moderate protein-calorie malnutrition
☐	E46	Unspecified protein-calorie malnutrition
	Other	
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____
☐	_____	_____

Exercise/Activity Plan:

☐ Release, _____ min/day OR _____ min/week

☐ Not Released

Comments: _____

Physician's Signature _____ **Date**_____

Physician's Name (Printed)_____

NPI #: _____

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

Relevant Lab Data or attach current labs

Date	Lab Value	
	BP:	mmHg
	Gluc:	mg/dL
	HbA1c:	%
	TC:	mg/dL
	HDL:	mg/dL
	LDL:	mg/dL
	TG:	g/dL
	BUN:	mg/dL
	ALB:	g/dL
	Creat:	mg/dL

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Please fax completed form to (855) 951-4406