Forms: Medical Nutrition Therapy Referral Form

REF

NMC health

600 Medical Center Drive | Newton, KS 67114

Registered Dietitian
Phone 316.804.6184
Fax 316.804.6262

Referral for Medical Nutrition Therapy (MNT)

Date:	Name:
Daytime Phone Number:	Insurance: (Attach copy of front & back of card)
DOB:	Home Address: Zip Code:

Above is referred for medical nutrition therapy as a necessary part of medical treatment and prevention of complication for diagnoses listed.

X Mark an X next to all diagnoses that apply to this referral

X	ICD-10	ICD-10 Description		X	ICD-10	ICD-10 Description
	E11.9	Diabetes Mellitus, Type II			N18.31	Chronic Kidney Disease, Stage 3a
	E10.9	Diabetes Mellitus, Type I			N18.32	Chronic Kidney Disease, Stage 3b
	E11.65	Diabetes Mellitus, Type II, Uncontrolled			N18.4	Chronic Kidney Disease, Stage 4
	E10.65	Diabetes Mellitus, Type I, Uncontrolled				
	O24.410	Gestational Diabetes			E66.01	Morbid obesity due to excess calories
					E66.09	Other obesity due to excess calories
	K90.0	Celiac Disease			E66.8	Other obesity
					E78.X	Hyperlipidemia
	R63.4	Abnormal Weight Loss			Z68.54	BMI, Pediatric, ≥ 95th%
					Z71.3	Dietary Counseling and Surveillance
	I10	Unspecified Essential Hypertension				

X Lab Work (Please attach)

BP _____/_____Recent visit notes (Please attach)

X Exercise/Activity Plan

☐ **Release:** may walk 20-30 mins. 5-7 x/ week for: _____

☐ **Not Released:** _____Date: _____

X Medications (Please attach list)

☐ Physician Signature: _____ Phone: _____

_____ 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 Operations Laws mandated by HIPAA.