



REF

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 | | | |
| | | | | | |

Lab Work (Please attach)

BP _____ / _____ Recent visit notes (Please attach)

Exercise/Activity Plan

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

Not Released: _____ Date: _____

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.