

Physician Referral Form For Medical Nutrition Therapy (MNT)

Patient Information:

Patient's name: _____

Patient's tele #: _____ Date of Birth: _____

Diabetes/Medical Diagnosis:

- | | |
|---|--|
| <input type="checkbox"/> Type 2, uncontrolled (E11.65) | <input type="checkbox"/> Pre-diabetes (R73.01) or (E74.9) |
| <input type="checkbox"/> Type 2 controlled (E11.9) | <input type="checkbox"/> Gestational diabetes/Pre-existing dm with pregnancy (O99.810) |
| <input type="checkbox"/> Type 1, uncontrolled (E10.65) | <input type="checkbox"/> Hypoglycemia, diabetic (E11.69) |
| <input type="checkbox"/> Type 1, controlled (E10.9) | <input type="checkbox"/> Obesity (E66.9)/Morbid Obesity (E66.01) |
| <input type="checkbox"/> Dyslipidemia (E78.5) | <input type="checkbox"/> Hypertension (I10) |
| <input type="checkbox"/> Hypertriglyceridemia (E78.1) | <input type="checkbox"/> Change in DM treatment plan: _____ |
| <input type="checkbox"/> Hypercholesterolemia (E78.0) | <input type="checkbox"/> Family hx of diabetes (Z83.3) |
| <input type="checkbox"/> OTHER (s) : _____ | |

Current Diabetes or Other Medical Treatment:

- Diet & Exercise
- Insulin Name/dosage: _____
- Oral Agents: Name: _____ dosage _____
Name: _____ dosage _____
Name: _____ dosage _____
Name: _____ dosage _____
- Medical/exercise restrictions: _____

Training Requested:

- insulin pump preparation
- Dexcom

Education Requested:

- | | |
|--|--|
| <input type="checkbox"/> Newly diagnosed diabetic | <input type="checkbox"/> Change in diabetes therapy |
| <input type="checkbox"/> Nutrition management | <input type="checkbox"/> Has or is at risk for complications |
| <input type="checkbox"/> Blood glucose monitoring and evaluation | <input type="checkbox"/> Unexplained hypoglycemia |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Weight reduction |
| <input type="checkbox"/> Elevated lipids | <input type="checkbox"/> All of the above |
| <input type="checkbox"/> Other: _____ | |

Standard Frequency: 1 time monthly **Duration:** 3 - 6 months/ **Other:** _____

ATTACHED DOCUMENTS:

- Health Insurance Card (both sides)
- Most Recent Laboratory Report

I certify that I am managing the beneficiary's diabetes condition and that Medical Nutrition Therapy (MNT) is a necessary part of management.

Physician's signature _____ Date: _____

Physician's printed name or office stamp
Physician's NPI: _____



DIETITIAN FOR DIABETES & WEIGHT CONTROL
WHERE EAST MEETS WEST

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