Physician Referral Form for Medical Nutrition Therapy (MNT)

Patient Information:

Patient's name: ____

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

Insurance: ______________________ Member ID #: ______________________

Diabetes/Medical Diagnosis:

- ☐ Type 2, **uncontrolled** (E11.65)
- ☐ Type 2 **controlled** (E11.9)
- ☐ Type 1, **uncontrolled** (E10.65)
- ☐ Type 1, **controlled** (E10.9)
- ☐ Dyslipidemia (E78.5)
- ☐ Hypertriglyceridemia (E78.1)
- ☐ Hypercholesterolemia (E78.0)
- ☐ Chronic Kidney Disease (N18)
- ☐ Pre-diabetes (R73.01) or (E74.9)
- ☐ Gestational diabetes/Pre-existing dm with pregnancy (O99.810)
- ☐ Hypoglycemia, diabetic (E11.69)
- ☐ Obesity (E66.9)/Morbid Obesity (E66.01)
- ☐ Hypertension (I10)
- ☐ Change in DM treatment plan: ______________
- ☐ Family hx of diabetes (Z83.3)
- ☐ 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/ refresher/ training
- ☐ Dexcom start or training

Education Requested:

- ☐ Newly diagnosed diabetic
- ☐ Nutrition management
- ☐ Blood glucose monitoring and evaluation
- ☐ Hypertension
- ☐ Elevated lipids
- ☐ Other: ______________________________
- ☐ Change in diabetes therapy
- ☐ Has or is at risk for complications
- ☐ Unexplained hypoglycemia
- ☐ Weight reduction
- ☐ All of the above

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.

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Physician's signature Date: ______________________

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Physician's printed name or office stamp

Physician's NPI: ______________________________

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