NOT YOUR AVERAGE *Nutritionist*

Office phone: 805-225-3027 Fax: 888-765-0374

**Referral for Medical Nutrition Therapy (MNT)**

| | |
|---|---|
| Date of referral: | Patient name & phone #: |
| RAF#: | Insurance (attach copy of front & back of card): |
| DOB: | Home address: |

**Referral needs**: __ New Referral __ New Treatment Plan / Complication __ Other:

**Patient Diagnosis** (attach additional sheets as needed):

| ICD-10 code | Description of ICD-10 Diagnosis |
|---|---|
| | |
| | |

**Lab work we generally like to see for eating disorders** (please attach, or just list out-of-range values):
CBC
CMP
Vit D____ Vit B12 ____ Mg _____ P04____
Thyroid panel
Lipid Panel
Urine (specific gravity)
Other:

**Orthostatic vitals**

| date: | **Supine** | **Sitting** | **Standing** |
|---|---|---|---|
| **BP & HR** | BP: HR: | BP: HR: | BP: HR: |

**Exercise Limitations/ Recommendations**:

**Medications & dosage:**

**Physician signature X_____**

**Print name: _____ NPI:_____**

**Phone: _____ Fax:_____**

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 HIPAA.