NOT YOUR AVERAGE Nutritionist

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 Diagnosis __ New Treatment Plan __ New Complication __ Other:

Patient Diagnosis (attach additional sheets as needed):

ICD-10 code	Description of ICD-10 Diagnosis

Lab work (please attach, or list ou- 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 (please attach list)

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.