



Physician Referral for Medical Nutrition Therapy

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Patient Information:

Patient Name: _____ DOB: _____

Home #: _____ Cell #: _____ Email: _____

Address: _____

Insurance Name: _____ Plan/Group #: _____

Physician Order: Registered Dietitian to assess and provide Medical Nutrition Therapy (MNT)

- ✓ Initial MNT (CPT code 97802)
- ✓ Follow-Up MNT (CPT code 97803)
- Additional MNT services in the same calendar year (Please specify change in diagnosis, medical condition or treatment regimen): _____

Diagnosis: Check diagnosis or add other diagnosed disease/ condition code

Please send with referral: office notes, weight history, medication list and lab work

<input type="checkbox"/> Abnormal weight gain R63.5	<input type="checkbox"/> Diabetes, Type 2 SPECIFY TYPE E11. _____	<input type="checkbox"/> Hypertension, essential I10
<input type="checkbox"/> Abnormal weight loss R63.4	<input type="checkbox"/> Diabetes, Gestational SPECIFY TYPE O24. _____	<input type="checkbox"/> Hypoglycemia, unspecified E16.2
<input type="checkbox"/> Anemia D64.9	<input type="checkbox"/> Diabetes, Type 1 w/ pregnancy SPECIFY TYPE O24. _____	<input type="checkbox"/> Hypothyroidism, unspecified E03.9
<input type="checkbox"/> Anemia, Iron Deficiency D50.9	<input type="checkbox"/> Diabetes, Type 2 w/ pregnancy SPECIFY TYPE O24. _____	<input type="checkbox"/> Irritable Bowel Syndrome w/ diarrhea K58.0
<input type="checkbox"/> Anorexia R63.0	<input type="checkbox"/> Diabetes, Pre R73.03	<input type="checkbox"/> Irritable Bowel Syndrome w/o diarrhea K58.9
<input type="checkbox"/> Anorexia Nervosa F50.00	<input type="checkbox"/> Diarrhea K59.1	<input type="checkbox"/> Malnutrition- Protein/calorie, moderate E44.0
<input type="checkbox"/> Bulimia F50.2	<input type="checkbox"/> Diverticulosis: specify type: K57. _____	<input type="checkbox"/> Malnutrition- protein/calorie mild E44.1
<input type="checkbox"/> Celiac Disease K90.0	<input type="checkbox"/> Diverticulitis: specify type: K57. _____	<input type="checkbox"/> Malnutrition – protein/calorie unspecified E46
<input type="checkbox"/> CKD Stage 1 N18.1	<input type="checkbox"/> Eating Disorder, unspecified F50.9	<input type="checkbox"/> Metabolic Syndrome E88.81
<input type="checkbox"/> CKD Stage 2 N18.2	<input type="checkbox"/> Failure to Thrive, Child R62.51	<input type="checkbox"/> Morbid Obesity E66.01
<input type="checkbox"/> CKD Stage 3 N18.3	<input type="checkbox"/> Failure to Thrive, Adult R62.7	<input type="checkbox"/> Obesity E66.09
<input type="checkbox"/> CKD Stage 4 N18.4	<input type="checkbox"/> Food Allergy K52.2	<input type="checkbox"/> Overweight E66.3
<input type="checkbox"/> CKD Stage 5 N18.5	<input type="checkbox"/> GERD, esophagitis K21.0	<input type="checkbox"/> Polycystic Ovary Syndrome E28.2
<input type="checkbox"/> Constipation, unspecified K59.00	<input type="checkbox"/> Hypercholesterolemia E78.00	<input type="checkbox"/> Underweight R63.6
<input type="checkbox"/> Crohn's Disease: Specify type K50. _____	<input type="checkbox"/> Hypertriglyceridemia E78.1	<input type="checkbox"/> Vitamin D Deficiency E55.9
<input type="checkbox"/> Diabetes, Type 1 SPECIFY TYPE E10. _____	<input type="checkbox"/> Hyperlipidemia, mixed E78.2	<input type="checkbox"/> Other: _____

MEDICARE MEDICAL NUTRITION THERAPY ELIGIBILITY CRITERIA:

Must provide ONE of these diabetes diagnostic criteria (date and value)

- FBG lab ≥ 126 mg/dl on 2 tests: FBG: _____ and FBG: _____
- 2 hr OGTT lab ≥ 200 mg/dl on 2 tests: 2 hr OGTT: _____ and 2 hr OGTT: _____
- Random BG lab ≥ 200 mg/dl with symptoms of uncontrolled diabetes: Random BG: _____
 - excessive thirst excessive urination excessive hunger blurry vision excessive tiredness unintentional wt loss
 - tingling in extremities other: _____

For MEDICARE Renal MNT (date and value)

- GFR lab: _____ (note: 13 to 50 required for Medicare eligibility)

I hereby certify that I am treating this patient for the above diagnosis and that the prescribed medical nutrition therapy is a necessary part of the patient's medical treatment.

Physician Signature: _____

Date: _____

Printed Physician Name: _____

NPI #: _____

Office Phone #: _____

Fax #: _____