# Medical Nutrition Therapy (MNT) Referral Form

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| Patient Name: | Referral Date |
| Home Address: | DOB: |
| Phone Number: | Insurance:<br>*Please attach copy of front & back of insurance card* |

The client listed above is being referred to your clinic for Medical Nutrition Therapy as an essential component of his/her medical treatment modalities and in the prevention of complications of the diagnosis listed below:

Referral Needs: ☐ New Diagnosis ☐ New treatment plan ☐ New complication ☐ Language

☐ Hearing/Speech/Vision ☐ Learning/Processing ☐ Other: _____

REFERRING DIAGNOSIS CODE (Please indicate diagnosis code to the highest level of specificity ):

| ✓ Check all diagnoses that apply to this referral | | | | | |
|---|---|---|---|---|---|
| ✓ | ICD-10 | ICD-10 Description | ✓ | ICD-10 | ICD-10 Description |
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**LAB DATA:** Please attach copy of most current labs

**CURRENT MEDICATIONS:** Please attach copy of most recent medication list

**EXERCISE/ACTIVITY RELEASE:**

☐ Released: May walk 20-30 min 5-7x/week or _____

☐ Not Released:_____ Reasons: _____

_____

**Location:** 1400 Market Place Blvd, Suite 216
Cumming, Georgia 30042
Phone: (770) 835-5954
Email: ueatrite@trekfit.com

Physician Signature: _____ Phone: _____

NPI:_____ Printed MD/DO/NP Name: _____ Fax: _____

Facility Name and Address: _____