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**Referral for Telehealth Medical Nutrition Therapy / Nutrition Counseling**

Thank you for your referral. Please note that referrals made in the easiest way for you is usually helpful. The following information will ensure that I have your patient's information & speed the process. I will stay in touch regarding nutrition plans & progress.

Date:	Patient Name:
Patient's day time phone number:	Patient Insurance: (please attach front and back of card)
Patient DOB:	Patient Home Address with Zip:

*This individual is referred for Medical Nutrition Therapy / nutrition counseling as a necessary part of medical treatment and prevention of complications for diagnoses listed.*

**Referral Needs:** \_\_\_\_New Diagnosis \_\_\_\_New treatment plan \_\_\_\_New complication

Special Needs: \_\_\_\_\_

**Diagnosis:** Please list all diagnosis that apply to this individual

ICD-10	ICD-10 Description	ICD-10	ICD-10 Description

**Lab Work & Anthros:** (Please attach or complete relevant)

BP: \_\_\_/\_\_\_ Ht:\_\_\_\_\_ Wt:\_\_\_\_\_

Hct/ Hgb	FBS	Hgb A1c	Total Chol	HDL/ LDL	TG	Other lipid	BUN/ Cr	Ua Micro Albumin / Cr	EGFR	Na/K	Phos/ PTH	Vit D	Other

**Exercise / Activity Plan:**

\_\_\_\_\_ **Release:** May walk 20-30 minutes 5-7x/wk or \_\_\_\_\_

\_\_\_\_\_ **Not Released:** \_\_\_\_\_

**Physician/NP Signature:** \_\_\_\_\_ **MD/DO 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 the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.