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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: X________________________________**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.