

Physician Referral for Medical Nutrition Therapy

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Patient Name: _____ Patient Phone: _____

Gender: M F D.O.B _____ Height: _____ Weight: _____

Physician's Order: _____ RD's Discretion _____ MD's diet prescription: _____

Medical Necessity: (Please provide ICD-9 codes for each DX checked.)

- | | |
|--------------------------|--------------------------------|
| _____ Diabetes Type 1 | _____ Celiac Disease |
| _____ Diabetes Type 2 | _____ Irritable Bowel Syndrome |
| _____ Gestational DM | _____ Fatigue |
| _____ Obesity/overweight | _____ Renal Impairment |
| _____ Hyperlipidemia | _____ Food sensitivities |
| _____ Hypertension | _____ Anemia |
| _____ Hypoglycemia | _____ Eating Disorder |
| _____ Pregnancy/Wks | |

Other: _____

Pertinent Lab Values: (Please fax a copy of most recent lab work)

- | | | |
|------------------|-----------------------|-----------------------|
| _____ Albumin | _____ Fasting Insulin | _____ TSH |
| _____ Hematocrit | _____ Hemoglobin | _____ Fasting glucose |
| _____ HbA1c | _____ Cholesterol | _____ LDL |
| _____ HDL | _____ Triglycerides | _____ LDL/HDL Ratio |

Other: _____

Pertinent Medications/Vitamins/Supplements:

Exercise Recommendations:

_____ Medical Clearance for Exercise _____ Exercise Limitations: _____

Special Instructions:

This medical nutrition therapy is a necessary part of the patient's medical treatment for the diagnoses listed above.

Physician's Signature Physician Name Physician Phone number Date