Hunter Bahre, RDN, CD-N	REFORMED NUTRITION REFORM YOUR HEALTH
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Referral for Medical Nutrition Therapy (MNT)

Date:	Patient name:
Day time phone number:	Insurance: (Attach copy of front & back of card)
DOB:	Home address: Zip:

Above is referred for *medical nutrition therapy* 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: ☐ Language ☐ Hearing/Speech/Vision ☐ Learning/Processing

✓ Check all diagnoses that apply to this referral

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

✓ **Lab work** (please attach or complete) BP _____/ _____

Hct/Hgb	FBS &/ or pc	Hgb A1C	Total Chol	HDL LDL	Non HDL	Trig	Ua Micro Albumin/Cr	BUN/ Cr	EGFR	Na/ K	Phos/ PTH	Vit D

✓ **Exercise/Activity Plan**

☐ **Release:** may walk 20-30 min 5-7 x/week or _____

☐ **Not Released:** _____

✓ **Medications-** Please attach list

✍ Physician signature **X**_____MD/DO Phone: _____

NPI: _____ _____ Fax: _____

Print MD/DO Name

The information above is Protected Health Information (PHI) and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Claim of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.