Location:
☐ Cass City
☐ Marlette

Medical Nutrition Therapy Services
3006 Main St, Marlette
Phone: 989-635-4348
Fax: 989-635-4315
6667 Main St, Cass City
Phone: 989-912-6368
Fax: 989-872-5441

Medical Nutrition Therapy Referral Form

Patient Name:	DOB:
Address:	Phone:
Insurance:	Policy #:
Prior-Authorization # (if needed):	

Diagnosis/Reason for MNT Referral: ☑ Z71.3: Dietary counseling and surveillance

Additional MNT Diagnoses
(Please check all that apply and alter as needed)

☐ Z68.__: Body Mass Index (BMI): _______________, adult	☐ I11.___: Hypertensive heart disease________________
☐ E66.0 : Obese due to excess calories	☐ E10.___: Type 1 diabetes mellitus__________________
☐ E66.01: Morbid (severe) obesity due to excess calories	☐ E11.___: Type 2 diabetes mellitus__________________
☐ E66.3: Overweight	☐ E16.1: Other hypoglycemia
☐ E66.8: Other Obesity	☐ E03.9: Hypothyroidism, unspecified
☐ E66.9: Obesity, unspecified – Obesity NOS	☐ N18.___: Chronic Kidney Disease, ___________________
☐ R63.4: Abnormal weight loss	☐ R73.03: Pre-diabetes
☐ R63.5: Abnormal weight gain – not during pregnancy	☐ K57. ___: Diverticulosis ____________________________
☐ R63.6: Underweight	☐ K21.___: Gastroesophageal reflux disease,___________
☐ K50.__: Crohn's Disease	☐ E78.0: Pure hypercholesterolemia
☐ E78.1: Pure hyperglyceridemia	☐ K58: Irritable bowel syndrome
☐ E78.2: Mixed hyperlipidemia	☐ K59: Constipation
☐ E78.5: Hyperlipidemia, unspecified	☐ K90.0: Celiac Disease
☐ E88.81: Metabolic syndrome	☐ E28.2: Polycystic ovarian syndrome
☐ F50.__: Anorexia nervosa, ______________	☐ O24.__ :Pre-existing diabetes mellitus type __, in pregnancy
☐ F50.2: Bulimia nervosa	☐ O24.410: Gestational diabetes mellitus, diet-controlled
☐ F50.9: Eating disorder, unspecified	☐ D50.8: Other iron deficiency anemias (d/t inadequate iron intake)
☐ K51: Ulcerative colitis	☐ I10: Essential (primary) hypertension
☐ _______ : ______________________________________	☐ _______ : ____

Please check any special needs (leave blank if none):

☐ Physical ☐ Hearing ☐ Vision ☐ Cognitive ☐ Language Barrier ☐ Other:_________________

Exercise:

☐ Unrestricted ☐ Restricted: ___________________________

Please also include:

- **Recent or related lab work**
- **Medication List**
- **Recent progress note or related office notes**

Physician's Printed Name (must be MD or DO):	Office Phone #:
	Office Fax #:
Physicians Signature:	Date: