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: