

Referral for Medical Nutrition Therapy (MNT)

UPMC
LIFE CHANGING MEDICINE
Western Maryland
Outpatient Nutrition Clinic
Fax: 240-964-8231

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Day Phone: _____ Evening Phone: _____

Insurance (Attach copy): _____

Referring Physician: _____ Primary Care Physician: _____

Above is referred for medical nutrition therapy as a necessary part of medical treatment and prevention of complications for diagnoses listed.

Referral Needs: (Check all that apply to this referral)

☐ New Diagnosis ☐ New treatment plan ☐ New complication

Special Needs: (Check all that apply to this referral)

☐ Language ☐ Hearing/Speech/Vision ☐ Learning/Processing

Other: _____

Diagnoses to be treated: (Please select all that apply)

- | | | |
|---|---|--|
| ☐ Obesity NOS/ E66.9 | ☐ Pre-bariatric surgery/ Z71.3 | ☐ CKD 3b/ N18.32 |
| ☐ Morbid Obesity/ E66.01 | ☐ Fatty Liver/ K76.0 | ☐ CKD 4/ N18.4 |
| ☐ Overweight/ E66.3 | ☐ Gastroparesis/ K31.84 | ☐ CKD 5/ N18.5 |
| ☐ Weight Gain/ R63.5 | ☐ Hypoglycemia/ E16.2 | ☐ Diverticulosis/ K57.3 |
| ☐ Weight Loss/ R64.3 | ☐ Pre-Diabetes/ R73.03 | ☐ GERD/ K21.9 |
| ☐ Underweight/ R63.6 | ☐ Diabetes 1/E10.65 uncontrolled | ☐ Celiac Disease/ K90.0 |
| ☐ Malnutrition/ E46 | ☐ Diabetes 1/E10.9 controlled | ☐ Irritable Bowel Syndrome/ K58 |
| ☐ Anorexia/ F50.019 | ☐ Diabetes 2/E11.65 uncontrolled | ☐ Crohn's/ K50.9 |
| ☐ MILD ☐ MODERATE ☐ SEVERE | ☐ Diabetes 2/E11.9 controlled | ☐ Other: Dx and code: _____ |
| ☐ Bulimia/ F50.20 | ☐ Hypertension/ I10 | ☐ Other: Dx and code: _____ |
| ☐ MILD ☐ MODERATE ☐ SEVERE | ☐ Hypercholesterolemia/ E78.0 | ☐ Other: Dx and code: _____ |
| ☐ Binge Eating Disorder/ F50.819 | ☐ Hyperlipidemia/ E78.5 | ☐ Other: Dx and code: _____ |
| ☐ MILD ☐ MODERATE ☐ SEVERE | ☐ Hypertriglyceridemia/ E78.1 | _____ |
| ☐ ARFID/ F50.82 | ☐ CKD 3a/ N18.31 | _____ |

Height: _____

Weight: _____

☐ Medical History: (attached) ☐ Medications (attached) ☐ 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 (Please check one):

☐ Release: May walk 20-30 minutes 5-7 x/week or _____

☐ Not Released: _____

Physician goals for patient: _____

Physician Signature: MD/DO required by CMS _____ Date: _____

Print Name: _____ NPI: _____

Phone: _____ Fax: _____