



Referral for Medical Nutrition Therapy

Date:	Patient Name:	DOB:
Patient Phone:	Insurance / ID:	
Referring Physician:		Phone:
		NPI:
Height:	Weight:	Gender:
Requested service: MNT _____ Hours of MNT requested: _____ / RDN to determine _____		

Medical Diagnosis (Check all that apply below)				
*Required for MNT/Insurance billing				
ICD-10	Endocrine/ Metabolic/ Nutritional	ICD-10	Digestive system	
E11.9	Diabetes II, no complications	K59	Constipation	
E 11.8	Diabetes II, unspecified complications	K59.1	Functional diarrhea	
E 10.9	Diabetes I, no complications	K58.0	Irritable bowel syndrome (IBS), diarrhea	
E10.8	Diabetes I, Unspecified complications	K58.1	Irritable bowel syndrome, constipation	
E28.2	Polycystic ovarian syndrome	K58.2	Irritable bowel syndrome (IBS), Mixed	
O24.410	Gestational diabetes, diet controlled	K90.0	Celiac disease	
O24.414	Gestational diabetes, insulin controlled	K21.9	GERD	
E74.9	Other disorders of carbohydrate metabolism, unspecified	K52.2	Allergic and dietetic gastroenteritis/colitis	
R73.09	Pre Diabetes	K51.9	Ulcerative colitis, unspecified	
E16.2	Hypoglycemia, unspecified	K50.9	Crohn's disease	
E03.9	Hypothyroidism, unspecified	K29.5	Chronic Gastritis, unspecified	
E66.9	Obesity, unspecified	K57.9	Diverticulosis of colon	
E66.3	Overweight	K82.9	Unspecified disease of gall bladder	
E78.0	Pure Hypercholesterolemia	K76.0	Fatty Liver	
E78.1	Pure Hyperglyceridemia		Genitourinary system	
E 78.2	Mixed Hyperlipidemia	N18.3	Chronic kidney disease, stage III	
E78.8	Disorders of lipoprotein metabolism	N18.4	Chronic kidney disease, stage IV	
E88.81	Metabolic Syndrome	N18.5	Chronic kidney disease, stage V	
E10.9	Gout, unspecified	N18.9	Chronic kidney disease, unspecified	
G47.33	Obstructive sleep apnea		Other	
	Circulatory System	L27.2	Dermatitis due to ingested food	
I10	Essential hypertension	Z71.3	Nutritional counseling & surveillance	
I15.9	Secondary hypertension		BMI _____	
I25	Chronic ischemic heart disease		Other: _____	
I50	Heart Failure		Other: _____	

*Please attach current list of medications and labs
 Recommendations / Goals:

Please fax form to: 888-974-4238 / Contact: 214-914-3778 / www.nutriliciousbyz.com

Physician Signature: _____ Date: _____