NutriliciousbyZ

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: _____