

# Referral for Medical Nutrition Therapy

REQUESTER'S NAME & CREDENTIALS :

ADDRESS:

PHONE:

FAX:

DATE:

PATIENT NAME:

DOB:

ADDRESS:

INSURANCE:

PHONE:

ICD-10	ICD-10 DESCRIPTION

The above is referred for **medical nutrition therapy** as a necessary part of medical treatment and prevention for the diagnoses listed.

ADDITIONAL NOTES:

PHYSICIAN'S FULL NAME:

PHYSICIAN'S SIGNATURE:

PHYSICIAN'S NPI:

DATE:

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ICD-10 Reference

ICD-10	ICD-10 DESCRIPTION
Z71.3	Dietary counseling + surveillance
R63.5	Abnormal weight gain
F50.01	Anorexia Nervosa/ Restricting type
F50.00	Anorexia Nervosa/ Unspecified
F50.82	Avoidant/restrictive food intake disorder (ARFID)
F50.81	Binge Eating Disorder
R73.03	Prediabetes
E11.65	Type 2 Diabetes w/ hyperglycemia
E11.9	Type 2 Diabetes w/out complications
O24.410	Gestational Diabetes/ diet controlled
E78.5	Hyperlipidemia/ unspecified
I10	Hypertension /Essential/Primary
E66.9	Obesity/ NOS
E66.3	Overweight