

Pediatric/Adult Referral for Medical Nutrition Therapy (MNT)

Please fax to: 800-888-9560 Office: 972-238-1811 13490 TI Blvd, Suite 102 Dallas, TX 75243

Please print Patient name:		Date of Birth:	
Best Contact number:	Guardian/Parent Name (if applicable)	Today's: Height	Weight
Reason for MNT referral/service:			
Physical Activity Restrictions: none: _____ limit to: _____			
<i>Please attach current lab results as available</i>			

MEDICAL DIAGNOSES (check all that apply below)				
[Required in order to initiate MNT service]				
	ICD-9	ENDOCRINE, NUTRITIONAL AND METABOLIC, IMMUNITY		ICD-9
	250.00	Diabetes II/unspecified		428.0 Congestive heart failure
	250.01	Diabetes I		DIGESTIVE SYSTEM
	250.02	Diabetes II/unspecified, uncontrolled		555.9 Crohn's disease NOS
	250.03	Diabetes I, uncontrolled		556.0 Ulcerative (chronic) enterocolitis
	250.1	Diabetes with ketoacidosis		562.10 Diverticulosis of colon
	251.2	Hypoglycemia, unspecified		562.11 Diverticulitis of colon
	256.4	Polycystic ovarian syndrome		564.1 Irritable bowel syndrome
	271.3	Intestinal disaccharidase deficiencies and disaccharide malabsorption		575.9 Unspecified disorder of gallbladder
	271.9	Unspecified disorder of carbohydrate transport and metabolism		579.0 Celiac
	272.0	Pure hypercholesterolemia		GENITOURINARY SYSTEM
	272.1	Pure hyperglyceridemia		585.3 Chronic kidney disease, Stage III (moderate)
	272.4	Combined hyperlipidemia		585.4 Chronic kidney disease, Stage IV (severe)
	272.2	Mixed hyperlipidemia		585.5 Chronic kidney disease, Stage V
	272.9	Unspecified disorder of lipid metabolism		585.6 End stage renal disease
	277.7	Dysmetabolic syndrome X		585.9 Chronic kidney disease, unspecified
	278.00	Obesity, unspecified		SKIN AND SUBCUTANEOUS TISSUE
	278.01	Morbid obesity		693.1 Dermatitis: Due to food
	278.02	Overweight		SYMPTOMS, SIGNS, ILL-DEFINED
		CIRCULATORY SYSTEM		783.21 Loss of weight
	401.0-401.9	Essential hypertension		790.2 Abnormal glucose
	402.0-402.9	Hypertensive heart disease		OTHER
	414.0	Coronary atherosclerosis		

MNT is a necessary part of the patient's medical treatment for the medical diagnosis (es) listed above.

Referring Provider Information

Printed Name _____	UPIN/NPI number: _____
Signature _____	Date: _____
Contact Information: P: _____	Fax: _____