Referral for Medical Nutrition Therapy (MNT)

Patient Name:	Referral Date:
Home address:	Patient Phone(s):
Insurance: *(Please attach copy of front and back of card)*	DOB:

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

Referral Needs: ☐ New Diagnosis ☐ New treatment plan ☐ New complication
☐ Language ☐ Hearing/Speech/Vision ☐ Learning/Processing
___ Other: ____

REFERRING DIAGNOSIS CODE (Please indicate diagnosis code to the highest level of specificity):

✓ Check all diagnoses that apply to this referral					
✓	**ICD-10**	**ICD-10 Description**	**✓**	**ICD-10**	**ICD-10 Description**
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		

LAB DATA:
Please attach copy of most current labs

CURRENT MEDICATIONS:
Please attach copy of most recent medication list

Exercise/Activity Release:
☐ Released: may walk 20-30 min 5-7x/week or ____________________________________
☐ Not released:____
Please provide any restrictions regarding exercise or physical activity.

Location: Please indicate which location the patient would prefer:
___ Downtown Decatur Office: 160 Clairemont Ave, Suite 200, Decatur GA 30030
___ Midtown/Atlantic Station: 201 17th St NW, Suite 300, Atlanta GA 30363 (Tuesday's only)
Phone: 770.853.0851 Fax: 678.951.0508 Email: david.orozco@tdwellness.com

Physician Signature: ____ Phone: _____________

NPI:___________________ Printed MD/DO Name: ____________________________ Fax: ______________

Facility Name and Address: ____

The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments and Healthcare Operation Laws mandated by HIPAA.