access to HEALTHCARE NETWORK

Medical Nutrition Therapy Referral Form

Please fax completed form to (775) 284-1915 OR
Email to healtheducation@accesstohealthcare.org

Medical Nutrition Therapy (MNT) includes nutritional diagnostic, therapeutic, and counseling services provided by a Registered Dietitian Nutritionist (RDN) for the purpose of disease management. Medical Nutrition Therapy has been shown to improve patient outcomes, quality of life and lower health-care costs.

Patient Information

Last Name ______ First Name ______ Middle ______

Date of Birth: ______ Gender: ☐ Male ☐ Female Language: ☐ English ☐ Spanish ☐ Other: ______

Address ______ City ______ State ______ Zip Code ______

Home Phone ______ Other Phone ______ E-mail address ______

Primary Payer Source (Health Insurance) ______ Primary Care Provider/Practice ______

Reason for Referral

Please indicate all diagnoses related to this referral, along with corresponding ICD-10 codes.

☐ ICD-10: ______ ☐ ICD-10 Description: ______
☐ ICD-10: ______ ☐ ICD-10 Description: ______
☐ ICD-10: ______ ☐ ICD-10 Description: ______

Medications *(please attach or complete)*

Medication	*Dosage/Frequency*

Lab Work *(please attach or complete)*

FBG	*Hgb A1c*	*Total Chol*	*HDL*	*LDL*	*Trig*	*Hct/ Hgb*	*Ua Micro Albumin/Cr*	*BUN/ Cr*	*EGFR*	*Na/K*	*Phos/ PTH*	*Vit D*

Special Needs *(select all that apply)*

☐ Mobility impairment ☐ Vision impairment ☐ Hearing impairment
☐ Cognitive impairment ☐ Language limitations ☐ Other ______

Provider Name: ______ **NPI:** ______
Group Practice: ______
Phone: ______ **Fax:** ______
Provider Signature: ______ **Date:** ______

For questions regarding this referral form, please call (775) 284-1898