EatWell Nutrition Counseling Services
10730 Potranco Road, Angela Garcia RDN/LD
Ste. 122-196, San Antonio, Texas 78251
210-630-2490 Info@eatwellncs.com Fax: 210 750 1160 NPI: 1366065245

Referral for Medical Nutrition Therapy (MNT)

Date:	Patient name:
Day time phone number:	Insurance: (Attach copy of front & back of card)
DOB:	Home address: Zip:

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

Special Needs: ☐ Language ☐ Hearing/Speech/Vision ☐ Learning/Processing

☐ Other:

✓ **Check all diagnoses that apply to this referral**

✓	ICD-10	Diagnosis	✓	ICD-10	Diagnosis
☐		Celiac Disease	☐		IBS
☐		CHF	☐		Impaired Fasting Glucose
☐		Cirrhosis of Liver	☐		Lactose Intolerance
☐		CKD stages 1-4	☐		Unspec. severe Protein-Calorie Malnutrition
☐		Crohn's Disease	☐		Moderate Protein-Calorie Malnutrition
☐		Diabetes - Gestational	☐		NASH
☐		Diabetes – Type 1	☐		Obesity
☐		Diabetes – Type 2	☐		Overweight
☐		End Stage Liver Disease	☐		PCOS
☐		Fructose Malabsorption	☐		Sleep Apnea
☐		GERD	☐		Ulcerative Colitis
☐		Gluten Sensitivity	☐		Vitamin Deficiency
☐		Hyperlipidemia	☐		Other:
☐		Hypertension	☐		
☐		Hypoglycemia	☐		

✓ **Lab work** (Please attach or complete) BP_____/_____

Hct/ Hgb	FBS &/or pc	Hgb A1c	Total Chol	HDL LDL	Non HDL	Trig	Ua Micro Albumin/Cr	BUN/ Cr	EGFR	Na/K	Phos/ PTH	Vit D

✓ **Exercise/Activity Plan**

☐ **Release:** may walk 20-30 min 5-7 x/week or _____

☐ **Not Released:** _____

✓ **Medications** – Please attach list

Physician signature X_____MD/DO Phone _____

NPI: _____ _____ Fax _____

Print MD/DO Name