Referral Fax Line: 704-246-6808

Matthews & Huntersville	MDD, Inc *Outpatient Nutrition Clinic* **Referral Form** **Medical Nutrition Therapy for Adults and Children**	Phone- 704-846-7105 Fax- 704-246-6808 Email Staff@MDDHelp.com Website www.MDDHelp.com

----------PATIENT INFORMATION----------

Name_____ Date of Birth_____

Address_____

Day Phone _____Evening Phone _____Insurance_____

Referring Physician_____Phone_____Fax_____

----------MEDICAL INFORMATION----------

Diagnosis: _____ ICD-10 DX Code_____

Reason for Referral: _____ Height _____Weight _____BP_____

Medical History/Complications: _____

Medications: _____

Laboratory Data	**Date**	**Result**
Fasting Glucose		
HbA1C		
Triglycerides		
Cholesterol		
LDL		
HDL		

----------MEDICAL NUTRITION THERAPY PLAN----------

Current Diet Therapy: **None or: _____**

Physician's Goals for Patient: _____

Physical Activity Limitations: **None or: _____**
***If None, Initial for Medical Clearance for Exercise_____**

PHYSICIAN SIGNATURE_____DATE_____
UPIN#_____NPI#_____

*****THIS FORM MUST BE COMPLETED IN ENTIRETY BEFORE PATIENT CAN BE SCHEDULED******

www.MDDHelp.com