

Referral Fax Line: 704-246-6808 Main Office Fax

Offices:
Matthews,
Huntersville,
Greensboro &
TELE-HEALTH!

MDD Nutrition
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-9 DX Code _____
Reason for Referral: _____ Height _____ Weight _____ BP _____
Medical History/Complications: _____
Medications: _____

<u>Laboratory Data</u>	<u>Date</u>	<u>Result</u>
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****

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