Positive Nutrition®
2936 S Highland Dr, Suite 100
Salt Lake City, UT 84106
FAX: 801-931-2156

# REFERRAL FOR MEDICAL NUTRITION THERAPY

*Please complete this form and fax it to 801-931-2156. We will then schedule the appointment directly with the patient. Since diagnosis is out of scope for the registered dietitian, we require documentation from the diagnosing provider in order to be able to bill insurance under that diagnosis. Completing this form helps us greatly to provide great service to our patients. Thanks in advance for your help!*

**Patient Information:**

| Name: | Date: |
| --- | --- |
| Insurance: | Date of Birth: |
| Phone Number: | Home Address: |

## Common Eating Disorder MNT Diagnostic Codes (ICD-10)

*These codes are provided for your convenience. Please check all that apply.*

| | |
| --- | --- |
| ☐ Anorexia nervosa, unspecified | F50.00 |
| ☐ Anorexia nervosa, restricting type | F50.01 |
| ☐ Anorexia nervosa, binge eating/purging type | F50.02 |
| ☐ Bulimia nervosa | F50.2 |
| ☐ Other eating disorders | F50.8 |
| ☐ Binge-eating disorder | F50.81 |
| ☐ Avoidant/restrictive food intake disorder | F50.82 |
| ☐ Other specified eating disorder | F50.89 |
| ☐ Eating disorder, unspecified | F50.9 |

Therapist Signature:______________________________ Therapist name: ______________________________

Group Name:____________________________________ Practice Phone Number:_______________________

Comments:

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.