



# 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 MNT Diagnostic Codes (ICD-10)

These codes are provided for your convenience. Please check all that apply and add in any additional codes in the "other" box or in comments

<input type="checkbox"/> Abnormal weight gain	R63.5	<input type="checkbox"/> Hyperlipidemia, unspecified	E78.5
<input type="checkbox"/> Abnormal weight loss	R63.4	<input type="checkbox"/> Pure hypercholesterolemia	E78.0
<input type="checkbox"/> Anemia, iron deficiency	D50.9	<input type="checkbox"/> Essential hypertension	I10
<input type="checkbox"/> Anorexia nervosa, unspecified	F50.00	<input type="checkbox"/> Metabolic syndrome	E88.81
<input type="checkbox"/> Anorexia nervosa, restricting type	F50.01	<input type="checkbox"/> Impaired fasting blood glucose	R73.01
<input type="checkbox"/> Anorexia nervosa, binge eating/purging type	F50.02	<input type="checkbox"/> Polycystic ovarian syndrome	E28.2
<input type="checkbox"/> Bulimia nervosa	F50.2	<input type="checkbox"/> Overweight	E66.3
<input type="checkbox"/> Binge-eating disorder	F50.81	<input type="checkbox"/> Obesity	E66.9
<input type="checkbox"/> Avoidant/restrictive food intake disorder	F50.82	<input type="checkbox"/> Mixed irritable bowel syndrome	K58.2
<input type="checkbox"/> Other specified eating disorder	F50.89	<input type="checkbox"/> Gastroparesis	K31.84
<input type="checkbox"/> Eating disorder, unspecified	F50.9	<input type="checkbox"/> Gastro-esophageal reflux disease w/o esophagitis	K21.9
<input type="checkbox"/> Hypothyroidism, unspecified	E03.9	<input type="checkbox"/> Constipation, unspecified	K59
<input type="checkbox"/> Prediabetes	R73.03	<input type="checkbox"/> Functional diarrhea	K59.1
<input type="checkbox"/> Diabetes, type I	E10.9	<input type="checkbox"/> Celiac disease	K90.0
<input type="checkbox"/> Diabetes, type II	E11.9	<input type="checkbox"/> Vitamin D deficiency, unspecified	E03.9
<input type="checkbox"/> Gestational diabetes	O24.41	<input type="checkbox"/> Other ICD-10 diagnosis	_____

Please send all pertinent labs, H&P, and any other supporting documentation of diagnosis. FAX: 801-931-2156

Referring Provider Signature: \_\_\_\_\_ Provider name: \_\_\_\_\_  
 Group Name: \_\_\_\_\_ Practice Phone Number: \_\_\_\_\_

Comments: