



Nutrition Harmony

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Referral for Medical Nutrition Therapy (MNT)

Nutrition Harmony, LLC

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Instructions: All fields below must be completed. Not doing so may delay care. **ICD-10 codes, last relevant chart notes, med list, labs, and treating provider signature *must* be included.** Retain faxed referral and documents as part of patient's medical record.

Referral Date:	Patient Name:	Date of Birth:
Patient Phone #:	Home Address, State, Zip Code:	Gender:
Insurance Plan:	Insurance ID:	Language Spoken/Written:
Referral Needs: <input type="checkbox"/> New Diagnosis	<input type="checkbox"/> New Treatment Plan	<input type="checkbox"/> New Complication
Special Needs: <input type="checkbox"/> Language	<input type="checkbox"/> Hearing/Speech/Vision	<input type="checkbox"/> Learning/Processing
		<input type="checkbox"/> Other:

*Reason for Referral - Referring Information Required as RDs cannot diagnose:	
ICD-10 Diagnosis Code	ICD-10 Code Diagnosis Description

Referring MD / DO:	NPI:	Exercise/Activity Plan: <input type="checkbox"/> Cleared to walk 30-60 min 5-7x/week or _____ _____
Phone:	Fax:	
Physician Signature (MD/DO): X _____		<input type="checkbox"/> Not Cleared *Attach last relevant lab work, chart/clinic/procedure notes, vital signs, and anthropometrics.

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.