[space for hospital/clinic/facility letterhead]

Medical Nutrition Therapy Referral Form

Patient's Last Name	First Name	Middle	Gender: ❑ male ❑ female	Medicare HICN # DOB:
Address				
Home Number	Work Number	Other Contact #s:		

MNT is Medicare Part B benefit for diabetes, pre-dialysis renal disease and the period of 36 months after kidney transplant. Research indicates that MNT is cost-effective as it improves outcomes.

Medical Nutrition Therapy (MNT):

(Check services being ordered)

Provided by a registered dietitian:

- ❑ Initial MNT
- ❑ Annual follow-up MNT
- ❑ Additional MNT services in the same calendar year per RD recommendations.
  Please specify change in diagnosis, medical condition or treatment regimen:
  ____
  ____
  ____

Diagnosis:

(Please send recent labs for outcomes evaluation)

❑ Type 1 controlled ❑ Type 1 uncontrolled
❑ Type 2 controlled ❑ Type 2 uncontrolled
❑ Gestational diabetes ❑ Renal disease
❑ Dyslipidemia ❑ Stroke ❑ CHD
❑ Hypertension ❑ Obesity

❑ Other: ____
____
____
____

Patient Behavioral Goals:

____
____
____
____

Desired Clinical Outcomes:

❑ A1c ________ ❑ B/P ________ ❑ LDL _________
❑ Total Cholesterol____________ ❑ HDL_________
❑ Triglycerides________________ ❑ GFR_________
❑ Other:____
____

Medications:

(Specify type, dose, frequency):

For Diabetes:

Oral: Insulin:

For Other:

Signature and UPIN#: Date:

Group/Practice Name, Address, and Phone Number: