

Daily Nutrition for Life LLC

Instructions: Complete this form and fax to Daily Nutrition for Life at 425-279-8975. We will contact the patient to schedule an appointment or the patient can call Daily Nutrition for Life at 425-900-3606 to schedule. We will notify you of the scheduled appointment. Please call with questions or to coordinate care.

Medical Nutrition Therapy (MNT) Referral Form

Please fax to: fax number

Patient Name: _____ DOB: _____
Phone: _____ Email: _____
Address: _____

Reason for MNT Referral:

Note: Please send pertinent labs, H&P, current medications, and other supporting documentation of diagnoses.

Common MNT Diagnostic Codes (ICD-10)

(ICD-10 codes are for your convenience, please alter/ change as needed & check all that apply below.)

<input type="checkbox"/> Abnormal Weight Gain	R63.5	<input type="checkbox"/> Hyperlipidemia	E78.5
<input type="checkbox"/> Anemia	D64.9	<input type="checkbox"/> Hypertensive Disorder	I10
<input type="checkbox"/> Anemia, Iron Deficiency	D50.9	<input type="checkbox"/> Hypoglycemia	E16.2
<input type="checkbox"/> Disorder of cardiovascular system	R94.3	<input type="checkbox"/> Irritable bowel syndrome	K58.9
<input type="checkbox"/> Celiac Disease	K90.0	<input type="checkbox"/> Other abnormal glucose	R73.09
<input type="checkbox"/> Constipation	K59.00	<input type="checkbox"/> Overweight	E66.3
<input type="checkbox"/> Congestive heart failure	I50.2	<input type="checkbox"/> Obese	E66.9
<input type="checkbox"/> Chronic kidney disease, unspecified	N18.9	<input type="checkbox"/> Ulcerative colitis, unspecified, without complications	K51.90
<input type="checkbox"/> Dietary surveillance and counseling	Z71.3	<input type="checkbox"/> Morbid Obesity	E66.01
<input type="checkbox"/> Diabetes, Type II	E11.9	<input type="checkbox"/> Pure Hypercholesterolemia	E78.0
<input type="checkbox"/> Diabetes mellitus, Type I, without complications.	E10.9	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Gastroesophageal Reflux Disease	K21.0	<input type="checkbox"/> Other	_____

Physician Signature: _____ Date: _____
Printed Name: _____ NPI: _____
Group/Practice Name: _____
Address: _____
Office Phone: _____ Fax: _____