BooneHealth

Nutrition and Diabetes Clinic

1701 East Broadway Columbia MO 65201

Phone: 573-815-3870 Fax: 573-815-8570

Referral for Medical Nutrition Therapy (MNT)

Patient name:	Patient DOB:
Home Phone Number:	Home address:
Insurance: (Attach copy of front & back of card)	
Referring Physician:	Referring Physician Phone Number:
Primary Physician:	Primary Physician Phone Number:

Patient is referred for *MNT as a necessary part of medical treatment* and prevention of complications for diagnoses listed.

Referral Needs: ☐ New Diagnosis ☐ New treatment plan ☐ New complication

Special Needs: ☐ Language ☐ Hearing/Speech/Vision ☐ Learning/Processing

☐ Other:_____

✔ **Diagnosis code that apply to this referral**

✓	ICD-10	ICD-10 Description	✓	ICD-10	ICD-10 Description
☐			☐		
☐			☐		
☐			☐		
☐			☐		

✔ **Lab work** (Please attach or complete) BP ____/ ____

Hct/ Hgb	FBS &/or pc	Hgb A1c	OGTT (2-Hr)	Total Chol	HDL LDL	Non HDL	Trig	uACR	BUN/ Cr	EGFR	Na/K	Phos/ PTH	Vit D

✔ **Exercise/Activity Plan**

☐ **Release:** may walk 20-30 min 5-7 x/week or ______________________________

☐ **Not Released:** ______________________________

✔ **Medications** – Please attach list

Please fax referral, medication list, labs and most recent office note to *573-815-8570*.

Physician Signature:______________________________ Date: ____________________

Printed MD/DO Name:______________________________

Notice: The information contained in the transmission accompanying this notice is confidential and intended only for the use of the individual or entity identified. If you have received this fax in error, please call 573-815-3870.

Name:______________________________ MR#:____________________ DOB:____________________	Nutritional Referral Form B-306A (6/23)