C🍎MPLEAT
WELLNESS STUDIO
Nutrition -Fitness - Health

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(717)-942-2831
Fax: 774-214-0767
julie@compleatwellness.us

Instructions: Complete this form and fax to 774-214-0767 or email to julie@compleatwellness.us. We will contact the patient to schedule an appointment, or the patient can call at 717-942-2831 to schedule.

Medical Nutrition Therapy (MNT) Referral Form

Patient Name: ______________________________ DOB: ________________________

Phone: ____________________________________ Email: _______________________

Address: ____

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

Reason for MNT referral:

Common MNT Diagnostic Codes (ICD-10)

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

Diagnosis	Code
Abnormal weight gain	R63.5
Loss of weight	R63.4
Disorder of cardiovascular system	R94.3
Celiac Disease	K90.0
Constipation	K59.00
Diabetes, Type II	E11.9
Other abnormal glucose	R73.09
Gastroesophageal Reflux Disease	K21.0
Pure hypercholesterolemia	E78.0
Hyperlipidemia	E78.5
Hypertensive disorder	I10
Hypoglycemia	E16.2

Diagnosis	Code
Irritable bowel syndrome	K58.9
Malnutrition of mild degree	E44.1
Malnutrition of moderate degree	E44.0
Other protein calorie malnutrition	E46
Obese	E66.9
Morbid obesity	E66.01
Polycystic Ovarian Syndrome	E28.2
Underweight	R63.6
Dietary surveillance & counseling	Z71.3
Other	______

☐ Check this box if you need another referral pad

Physician Signature: ______________________________ Date: ___________________________

Printed Name: ___________________________________ NPI: ____________________________

Group/Practice Name: ____

Address: ____

Office Phone: ____