TOA
TENNESSEE ORTHOPAEDIC ALLIANCE

MEDICAL NUTRITION THERAPY (MNT) REFERRAL

Fax the following information to: 629-666-3352

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____/_____/_____ Phone: _____
Patient Address: _____ Insurance: _____

DIAGNOSIS FOR MNT (ICD-10 codes are required, check all that apply)

Please specify the diagnosis in the blanks, e.g., E10.65 (type 1 diabetes with hyperglycemia).

- ❑ E10.___Type 1 DM
- ❑ E11.___Type 2 DM
- ❑ E28.2 PCOS
- ❑ E66.___ Overweight/Obesity
- ❑ E78.0 Pure Hypercholesterolemia
- ❑ E78.2 Mixed hyperlipidemia
- ❑ E88.81 Metabolic Syndrome
- ❑ N18.___ CKD (stages 3-5)
- ❑ F50.___ Anorexia nervosa
- ❑ F50.2 Bulimia nervosa
- ❑ F50.9 Eating disorder, unspecified
- ❑ I10 HTN, essential
- ❑ I11.0 HTN heart disease with CHF
- ❑ K21.___ GERD
- ❑ K50.___ Crohn's disease
- ❑ K51 Ulcerative colitis
- ❑ K52.2 Food Allergies
- ❑ K58 Irritable bowel syndrome
- ❑ K90.0 Celiac disease
- ❑ R63.4 Abnormal weight loss
- ❑ R63.5 Abnormal weight gain
- ❑ R63.6 Underweight
- ❑ R73.01 Impaired FBG
- ❑ R73.03 Pre-diabetes
- ❑ Z71.3 Dietary Counseling and Surveillance
- ❑ _____
- ❑ _____
- ❑ _____

REASON FOR REFERRAL (required)

Provider Comments:

Exercise Restrictions? ____ YES ____ NO Specify:

Referring Provider Name (print) _____

Provider Signature _____

Provider NPI: _____ Date of referral: _____/_____/_____

Provider Phone: _____ Provider Fax: _____