Nutrition Harmony

Alexandra C. Sanchez, RD

Referral for Medical Nutrition Therapy (MNT)

Nutrition Harmony, LLC

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Instructions: All fields below must be completed. Not doing so may delay care. **ICD-10 codes, last relevant chart notes, med list, labs, and treating provider signature *must* be included.** Retain faxed referral and documents as part of patient's medical record.

Referral Date:	**Patient Name:**	**Date of Birth:**
Patient Phone #:	**Home Address, State, Zip Code:**	**Gender:**
Insurance Plan:	**Insurance ID:**	**Language Spoken/Written:**

Referral Needs: ☐ New Diagnosis ☐ New Treatment Plan ☐ New Complication ☐ Other:

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

***Reason for Referral - Referring Information Required as RDs cannot diagnose:**

ICD-10 Diagnosis Code	**ICD-10 Code Diagnosis Description**

Referring MD / DO:	**NPI:**	**Exercise/Activity Plan:**
Phone:	**Fax:**	☐ **Cleared** to walk 30-60 min 5-7x/week or _____ _____
Physician Signature (MD/DO): X_____		☐ **Not Cleared** ***Attach last relevant lab work, chart/clinic/procedure notes, vital signs, and anthropometrics.**

The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.