Alamo Nutrition Consultants

Referral for Medical Nutrition Therapy

Please attach current list of medications, dosages & current lab results.

Office: (210)971-0044 Fax: (210)212-7403 www.ANCtexas.com

Date:	Patient name:	Date of Birth:
Day time phone number:	Insurance:	Medical Record Number:
Height: Weight:	Waist Circumference:	Gender: Male____ Female____
Requested service:____ Initial MNT (97802)___Follow-up MNT (97803) _____ Hours of MNT requested		

****REASON FOR ORDERING MNT** MEDICAL DIAGNOSES (check all that apply below) [Required in order to initiate MNT service]**					
	ICD-10	**ENDOCRINE, NUTRITIONAL AND METABOLIC, IMMUNITY**		**ICD-10**	**DIGESTIVE SYSTEM**
	E11.9	Diabetes II/without complications		K21.9	Gastroesophageal reflux disease
	E11.65	Diabetes II/unspecified, uncontrolled		K50.9	Crohn's disease, unspecified
	E10.9	Diabetes I/without complications		K51	Ulcerative (chronic) enterocolitis
	E10.65	Diabetes I/unspecified, uncontrolled		K57.1	Diverticulosis, small intestine
	E78.0	Pure hypercholesterolemia		K57.3	Diverticulosis, large intestine
	E78.1	Pure hyperglyceridemia		K58	Irritable bowel syndrome
	E78.2	Mixed hyperlipidemia		K90.0	Celiac Disease
	E78.5	Combined hyperlipidemia		K31.84	Gastroparesis
	E88.81	Metabolic Syndrome		K90.9	Intestinal malabsorption (unspecified)
	E66.0	Obese due to excess calories			**GENITOURINARY SYSTEM**
	E66.01	Morbid (severe) obesity		N18.3	Chronic kidney disease, Stage III (moderate)
	E66.9	Obesity, unspecified		N18.4	Chronic kidney disease, Stage IV (severe)
	E66.3	Overweight		N18.5	Chronic kidney disease, Stage V
		CIRCULATORY SYSTEM		N18.6	End stage renal disease
	I10	Essential (primary) hypertension		N18.9	Chronic kidney disease, unspecified
	I25.10	Atherosclerotic heart disease			**OTHER**
	I50.9	Heart Failure, unspecified			
		SKIN AND SUBCUTANEOUS TISSUE			
	L27.2	Dermatitis: Due to food			
		SYMPTOMS, SIGNS, ILL-DEFINED			
	R62.7	Failure to Thrive/Malnutrition			
	R63.4	Abnormal weight loss			

Relevant Medications and Dosages: ***(please attach and fax with this form)***

Relevant Lab Data: (attach current lab data)

Physical Activity Restrictions***: None:_____ Limit to:_____***

Comments ***(medical conditions, goals for nutrition therapy):*** _____

MNT is a necessary part of the patient's medical treatment for the medical diagnosis (es) listed above.

Physician's Signature _____ ***Date*** _____

NPI Number:_____ *****Please Fax to (210) 212-7403*****