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Physician Referral Form for Medical Nutrition Therapy by a Registered Dietitian

Please send this completed form to the patient's health insurance payor and
Fax completed form along with pertinent labs, H&P to Be Well with Beth's secure fax line: (866) 277-0164

Patient's Name: _____ **Patient's DOB:** _____

Patient phone number/email: _____

Reason for referral:

Diagnosis and diagnosis code: ***Please check all appropriate ICD-10 codes below***

Common MNT Diagnostic Codes (ICD-10)
(ICD-10 codes are for your convenience, please alter/ change as needed & check all that apply below.)

☐ Abnormal Weight Gain	R63.5	☐ Other abnormal glucose	R73.09
☐ Loss of weight	R63.4	☐ Gastroesophageal Reflux Disease	K21.0
☐ Anemia	D64.9	☐ Pure Hypercholeterolemia	E78.0
☐ Anemia, Iron Deficiency	D50.9	☐ Hyperlipidemia	E78.5
☐ Anorexia	R63.0	☐ Hypertensive Disorder	I10
☐ Anorexia Nervosa	F50.00	☐ Hypoglycemia	E16.2
☐ Anorexia Nervosa, restricting type	F50.01	☐ Irritable bowel syndrome	K58.9
☐ Anorexia Nervosa, binge eating/purging type	F50.02	☐ Malnutrition of mild degree	E44.1
		☐ Malnutrition of moderate degree	E44.0
☐ Atypical Anorexia Nervosa	F50.02	☐ Other protein calorie malnutrition	E46
☐ Bulimia Nervosa	F50.02	☐ Overweight	E66.3
☐ Atypical Bulimia Nervosa	F50.9	☐ Obese	E66.9
☐ Binge Eating Disorder	F50.8	☐ Morbid Obesity	E66.01
☐ Eating Disorder, Unspecified	F50.9	☐ Polycystic Ovarian Syndrome	E28.2
☐ Other disorders of eating	F50.9	☐ Underweight	R63.6
☐ Disorder of cardiovascular system	R94.3	☐ Dietary surveillance and counseling	Z71.3
☐ Celiac Disease	K90.0		
☐ Constipation	K59.00	☐ Other	_____
☐ Diabetes, Type II	E11.9	☐ Other	_____

Physician Name and NPI: _____ **Physician Signature** _____**(date)**

Physician Phone Number: _____ **Physician Fax** _____