HEALTHY MISSION DIETITIAN, INC.
NUTRITION THERAPY & WELLNESS

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Referral for Medical Nutrition Therapy (MNT)

Please fax this sheet along with the following information to (626) 231-0616
· Facesheet/insurance information. · Recent physician note · Labs · Medication list

Patient Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

Insurance: _____

Referral Needs: ☐ Initial MNT Referral ☐ Annual MNT Referral (ongoing nutrition therapy)
☐ Additional MNT Request d/t change in condition or treatment plan *(indicate below)*

Change in Condition or Treatment for additional MNT request: ☐ new dx or comorbidity
☐new or abnormal lab values ☐ Significant weight change ☐Medication initiation or adjustment
☐poor or changing glycemic control ☐post-hospitalization ☐ progression or improvement of disease
☐Other: _____

Check all diagnoses that apply to this referral

Type 1 Diabetes
☐ E10.64 Type 1 diabetes w/ hypoglycemia
☐ E10.65 Type 1 diabetes w/ hyperglycemia
☐ E10.9 Type 1 diabetes w/ no complications

Type 2 Diabetes
☐ E11.64 Type 2 diabetes w/ hypoglycemia
☐ E11.65 Type 2 diabetes w/ hyperglycemia
☐ E11.8 Type 2 diabetes w/ no complications

Kidney Disease
☐ N18.31 CKD Stage 3a (GFR 45-59)
☐ N18.32 CKD Stage 3b (GFR 30-44)
☐ N18.4 CKD Stage 4 (GFR 15-30)
☐ N18.5 CKD Stage 5 (<15)

Cardiovascular, Endocrine, & Metabolic Diseases
☐ I10 Hypertension
☐ E78.0 Pure Hypercholesterolemia
☐ E78.5 Hyperlipidemia, unspecified
☐ E88.81 Metabolic Syndrome
☐ R73.01 Impaired Fasting Blood Glucose
☐ R73.03 Pre-Diabetes

Weight Management
☐ E66.3 Overweight
☐ E66.9 Obesity, unspecified

Other
☐ Z71.3 Dietary Counseling & Surveillance
☐ _____
☐ _____

☐I certify that MNT is medically necessary for management of this patient's condition
☐I certify that additional MNT services are required due to change in medical condition or treatment regimen requiring reassessment of the nutrition care plan

Physician Signature: _____ Date: _____ NPI: _____

Provider Name: _____ Phone: _____ Fax: _____

For Medicare patients – referral must be completed by MD or DO only

(Form updated: 2026-03-04)