North Texas Nutrition

Medical Nutrition Therapy Referral Form

(214) 601-7057; FAX: (972) 777-1619
www.northtxnutrition.com; NorthTexasNutritionLLC@gmail.com

Patient's Name: ____
DOB: ______________ Phone Number: ____________________
Email: ____

ICD-10 Codes

☐ E11.__ Specified Diabetes Mellitus ☐ R73.9 Hyperglycemia ☐ N18.9 Chronic Kidney Disease, unspecified ☐ N18.3 Chronic Kidney Disease Stage III ☐ N18.4 Chronic Kidney Disease Stage IV ☐ I10 Essential Hypertension ☐ E78.00 Pure Hypercholesterolemia ☐ R63.4 Abnormal Weight Loss ☐ R63.6 Underweight ☐ R62.7 Failure to Thrive ☐ E46 Unspecified Protein Calorie Malnutrition ☐ E55.9 Vitamin D Deficiency ☐ K90.0 Celiac Disease	☐ K58.0 Irritable Bowel Syndrome with Diarrhea ☐ K58.9 Irritable Bowel Syndrome without Diarrhea ☐ K59.00 Constipation ☐ K31.84 Gastroparesis ☐ K21.9 Gastroesophageal Reflux Disease without Esophagitis ☐ E66.01 Morbid Obesity ☐ E66.09 Other Obesity d/t excess calories ☐ E66.1 Drug-Induced Obesity ☐ E66.3 Overweight ☐ E66.8 Other Obesity ☐ E66.9 Obesity, Unspecified ☐ E88.81 Metabolic Syndrome ☐ Z68.__ BMI ______________

**Other Dx and ICD-10 Code/s (specify): ____
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PLEASE FAX THIS FORM AND PERTINENT LABS TO (972) 777-1619

Reason for Referral

☐ Weight Reduction Needed ☐ Weight Gain Needed ☐ Diabetes Medical Nutrition Therapy	☐ Specific Nutrient Education ☐ Specific Diet education ☐ Other: ____________________

Print Physician's Name: _______________________________
Physician's Phone/Fax: _______________________________
Physician's Signature: ________________________________
Date: ____