REFERRAL FOR OUTPATIENT MEDICAL NUTRITION THERAPY

To **schedule an appointment** please use Epic Scheduling or call Central Scheduling at 800-659-6762.
Please **fax this form** to 423-431-1886 along with the most recent & relevant clinical information, physician notes and lab work (such as hemoglobin A1c, lipid profile, blood pressure, height, weight, growth charts, allergy panels).

(identification)

Medical Nutrition Therapy Clinic:

- ❑ Greeneville Community Hospital East - Greeneville, TN
- ❑ Norton Community Hospital - Norton, VA
- ❑ Smyth County Community Hospital - Marion, VA
- ❑ Hawkins County Memorial Hospital - Rogersville, TN
- ❑ Johnson City Medical Center - Johnson City, TN
- ❑ Russell County Hospital - Lebanon, VA
- ❑ Sycamore Shoals Hospital - Elizabethton, TN

Patient Name: _____ DOB: _____
Address: _____ City: _____ State/Zip: _____
Telephone #: _____ Patient Insurance: _____

Please check ALL applicable reasons for referral. Write in any additional diagnoses with ICD-10 codes.
A diagnosis is required before scheduling any patient appointment.

✓	Diagnosis	Code		✓	Diagnosis	Code
	Abnormal Weight Gain	R63.5			Hypertension	I10
	Allergies, Food Related	L27.2			Hypertriglyceridemia	E78.1
	Anorexia Nervosa	F50.00			Hypoglycemia	E16.2
	Bulimia Nervosa	F50.2			Insulin Resistance/Metabolic Syndrome	E88.81
	Current Cancer of _____	C80.1			Irritable Bowel Syndrome	K58.9
	Celiac Disease	K90.0			Loss of Appetite/Anorexia	R63.0
	Chronic Kidney Disease, Stg III, pre-dialysis	N18.3			Malnutrition, Mild Protein-Calorie	E44.1
	Chronic Kidney Disease, Stg IV, pre-dialysis	N18.4			Malnutrition, Moderate Protein-Calorie	E44.0
	Constipation	K59.00			Malnutrition, Severe Protein-Calorie	E43
	Congestive Heart Failure	I50.9			Malnutrition, Unspecified Protein-Calorie	E46
	Crohn's Disease	K50.019			Morbid Obesity	E66.01
	Diabetes Mellitus, Type 1, uncontrolled	E10.65			Nutritional Deficiency, Unspecified	E63.9
	Diabetes Mellitus, Type 1, without complications	E10.9			Obesity (adult or child)	E66.9
	Diabetes Mellitus, Type 2, uncontrolled	E11.65			Overweight (adult or child)	E66.3
	Diabetes Mellitus, Type 2, without complications	E11.9			Polycystic Ovary Syndrome	E28.2
	Dietary Counseling & Surveillance	Z71.3			Post Kidney Transplant	Z94.0
	Dysphagia	R13.10			Prediabetes/Abnormal Glucose	R73.09
	Failure to Thrive, Adult	R62.7			Pregnancy (not principle diagnosis)	Z33.1
	Failure to Thrive, Child	R62.51			Short Gut Syndrome	K91.2
	Feeding Difficulty/Food Refusal/Picky Eating	R63.3			Tube-feeding	Z93.1
	Gestational Diabetes	O24.419			Under Weight	R63.6
	HIV/AIDS	B20			Vitamin Deficiency:	E56.9
	Hyperemesis Gravidarum, Mild	O21.0				
	Hyperlipidemia	E78.5				

Referral Plan of Care:

_____ number of visits ❑ Initial Medical Nutrition Therapy (MNT) ❑ Follow-up MNT
❑ Additional MNT hours in same calendar year _____ hours
Please specify change in medical condition, treatment and/or diagnosis _____
(Medicare: 3 hours initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.)

Special Needs: ❑ Language _____ ❑ Hearing/Speech/Vision ❑ Learning/Processing ❑ Wheelchair Access

Patient's Physical Activity Readiness: ❑ Release: Patient may walk 20-30 minutes 5-7 times/week or _____
❑ Not Released: _____

Physician Information

I have referred the above patient for medical nutrition therapy as a necessary part of medical treatment and prevention of complications.
Physician Name: _____ Practice Name: _____
Address: _____
Fax #: _____ Telephone #: _____

Time: _____ Date: _____ Physician Signature (REQUIRED): _____