Nutrition Services

Rosae Calvo, RDN, LD
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Pay-Less Markets, Inc.

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REFERRAL FORM

Medical Nutrition Therapy (MNT)

Patient Information

Name:	DOB:
Address:	Phone Number:
Insurance: (attach copy of front & back of card)	

Above is referred for *medical nutrition therapy as a necessary part of medical treatment* and prevention of complications for diagnoses listed.

Referral Needs:

☐ New Diagnosis ☐ New treatment plan ☐ New complication

☐ Follow-up MNT ☐ Other

✔ CHECK ALL DIAGNOSES THAT APPLY TO THIS REFERRAL					
✔	**ICD-10**	**ICD-10 Description**	**✔**	**ICD-10**	**ICD-10 Description**
	E11.64	**Type 2 diabetes mellitus with hypoglycemia**		I10	Essential (primary) hypertension
	E11.65	Type 2 diabetes mellitus with hyperglycemia		E78.5	Hyperlipidemia, unspecified
	E11.8	Type 2 diabetes with unspecified complications		E88.81	Metabolic syndrome
	E11.9	Type 2 diabetes without complications		K58	Irritable bowel syndrome
	E66.3	Overweight		K90.0	Celiac disease
	E66.9	Obesity, unspecified		M10.9	Gout, unspecified
	R63.6	Underweight		R73.09	Other abnormal fasting glucose (pre-diabetes)
	Z71.3	Dietary counseling and surveillance			Other:_______________

The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.

✔ **Lab Work** (Please attach or complete)

BP ________/ ________

FBS	Hgb A1c	Total Chol	LDL-C	HDL-C	Trig	Renal GFR

✔ **Exercise/Activity Plan**

☐ **Release:** May walk 20-30 minutes, 5-7x/week or ______________

☐ **Not Released:** ____

✔ **Medications -** Please attach list

This medical nutrition therapy is a necessary part of the patient's medical treatment for the diagnoses listed above.

Physician Signature:______________________ Date: ____________

Print Name: _____________________________ NPI: _____________

Please FAX, MAIL, or EMAIL completed referral form to Rosae Calvo:
Super Drug Dededo: Fax: 671.637.9747
Address: 214 W. Marine Drive, Route 1 Dededo, Guam 96929
Email: rosaec@paylessmarkets.com

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