Physician Referral for Medical Nutrition Therapy

Beaufort County Public Health Department

1436 Highland Dr, Washington, NC 27889

Phone (252)946-1902   Fax (252)946-8430

Attn: Lynn House

Patient: ____ **DOB:** _____________**Gender** ☐ **M** ☐ **F**

Address: ____ **Phone:** ____________________________

Insurance: ____________________________________ **Policy No:** ____________________________________

Interpreter Needed ☐Yes ☐No **Physical Activity Restrictions** ☐Yes ☐ NO

Reason for MNT Referral (Please include date collected)

☐**Overweight**

(wt______ ht_______ BMI______ Date______________)

☐**Underweight**

(wt______ ht_______ BMI______ Date______________)

☐**Anemia** (Hgb/Hct__________ Date ___________)

☐**HTN** (BP_____________ Date _______)

☐**High Cholesterol**

(TC_______ LDL______HDL_____TG_____ Date ______________)

☐**Diabetes** (BG______ Date _______A1C______Date_______)

☐**Failure To Thrive**

Medical Diagnosis

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ICD-10 code(s)

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Parent/Guardian Name if minor: ____

I hereby certify that I am managing this beneficiary's medical conditions and that the prescribed Medical Nutrition Therapy is a necessary part of management.

Name of Practice: (Required) ____

Provider's Signature: (Required) ____

Provider's Name: (Printed) ____**NPI#** ______________________

Telephone: __________________________________ **Fax:** ____

REV 10/26/17