Referral for Medical Nutrition Therapy
Beaufort County Public Health Department
Phone (252)940-6526 Fax (252)946-8430
Attn: Lynn House

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

Address: ____ **Phone:** ___________________________

Insurance: ______________________ ****Parent Name if minor:** ___________________________________

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**
(wt______ ht_______ BMI______ Date_____________)

Medical Diagnosis

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ICD-10 code(s)

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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:** ____

Date: ______________________________________

Please fax recent Medical notes or chart information related to the referral.

REV 10/29/18