Positive Nutrition®
2936 S Highland Dr, Suite 100
Salt Lake City, UT 84106
FAX: 801-931-2156

REFERRAL FOR MEDICAL NUTRITION THERAPY

Please complete this form and fax it to 801-931-2156. We will then schedule the appointment directly with the patient. Since diagnosis is out of scope for the registered dietitian, we require documentation from the diagnosing provider in order to be able to bill insurance under that diagnosis. Completing this form helps us greatly to provide great service to our patients. Thanks in advance for your help!

Patient Information:

Name:	Date:
Insurance:	Date of Birth:
Phone Number:	Home Address:

Common MNT Diagnostic Codes (ICD-10)

These codes are provided for your convenience. Please check all that apply and add in any additional codes in the "other" box or in comments

Diagnosis	Code	Diagnosis	Code
☐ Anorexia nervosa, restricting type, unspecified	F50.019	☐ Hyperlipidemia, unspecified	E78.5
☐ Anorexia nervosa, binge/purge type, unspecified	F50.029	☐ Pure hypercholesterolemia	E78.0
☐ Bulimia nervosa, unspecified	F50.20	☐ Essential hypertension	I10
☐ Binge-eating disorder, unspecified	F50.819	☐ Metabolic syndrome	E88.81
☐ Avoidant/restrictive food intake disorder	F50.82	☐ Impaired fasting blood glucose	R73.01
☐ Other specified eating disorder	F50.89	☐ Polycystic ovarian syndrome	E28.2
☐ Eating disorder, unspecified	F50.9	☐ Overweight	E66.3
☐ Anemia, iron deficiency	D50.9	☐ Obesity	E66.9
☐ Vitamin D deficiency, unspecified	E03.9	☐ Mixed irritable bowel syndrome	K58.2
☐ Celiac disease	K90.0	☐ Gastroparesis	K31.84
☐ Functional diarrhea	K59.1	☐ Gastro-esophageal reflux disease w/o esophagitis	K21.9
☐ Hypothyroidism, unspecified	E03.9	☐ Constipation, unspecified	K59
☐ Prediabetes	R73.03	☐ Gestational diabetes	O24.42
☐ Diabetes, type I	E10.9	☐ Other ICD-10 diagnosis	______
☐ Diabetes, type II	E11.9	☐ Other ICD-10 diagnosis	_______

Please send all pertinent labs, H&P, and any other supporting documentation of diagnosis. FAX: 801-931-2156

Referring Provider Signature:_______________________________ Provider name: _______________________________
Group Name:_____________________________________ Practice Phone Number:________________________

Comments:

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.