



Medical Nutrition Therapy Center

Date of Referral: _____

Name: _____

Date of Birth: _____

Insurance: _____

Pre-certification #: _____

Referring Practitioner: _____

Patient's contact #: _____

Referring diagnosis/reason for referral: _____

NOTE:

Please inform your patients that some referrals are not covered by insurance. For example, Medicare will only cover outpatient nutrition counseling for diabetes and renal disease diagnosis.

Type of Diabetes:

- New Diagnosis
- Pre-existing
- Type 1, uncontrolled
- Type 1, controlled
- Type 2, uncontrolled
- Type 2, controlled
- Gestational
- Pre-diabetes
- Other _____

Please provide special needs for consultation

- Impaired vision
- Language Barrier
- Hard of Hearing
- Other _____

Medical Nutrition Therapy (MNT)

- Diabetes Cholesterol Lowering Renal Disease
- Weight Management
 - Obesity
 - Bariatric Counseling: Group and/or Individual Session
- Other (please specify: _____)

Referring provider's signature: _____

1. Fax order form, current labs, and medical history to **585-396-6492**.
2. **Instruct patient to call 585-396-6433** to schedule their appointment.

Thank you for your referral to the Medical Nutrition Therapy Center at UR/Thompson Health