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

Last Revised 11/27/2018