HEALTHY HIVE
FAMILY NUTRITION

Physician Referral Form for Medical Nutrition Therapy

Please fax this referral form to (737) 241-1851 or e-mail to contact@healthyhivenutrition.com. The patient's guardian can contact us directly at (737) 377-1561 or via e-mail to schedule an appointment.

Patient Information	**Physician Information**
Name:	Name:
Address:	Group/Practice Name:
Phone:	Phone:
Date of Birth:	Fax:
Insurance Company:	Physician NPI:
Policy Number:	

Reason for Referral:

Required: Below you will find the most commonly used MNT ICD-10 codes that we work with at our practice. **Please check all that apply to this referral.** You may add a unique code in the blank boxes if needed.

✔	ICD-10	Description	✔	ICD-10	Description
	Z71.3	Dietary counseling and surveillance		K59.1	Functional diarrhea
	Z68.5_	BMI, pediatric, _____ percentile for age		K90.0	Celiac disease
	R62.51	Failure to thrive, child		E78.5	Hyperlipidemia, unspecified
	R633	Feeding difficulties		I10	Essential (primary) hypertension
	D50.8	Other iron deficiency anemias (due to inadequate iron intake)		E11._	Type 2 diabetes mellitus
	E73.9	Lactose intolerance, unspecified		R73.03	Prediabetes
	Z91.01_	(Food) allergy to _____		R73.9	Hyperglycemia, unspecified
	K58	Irritable bowel syndrome			
	K59	Constipation			

This medical nutrition therapy is a necessary part of the patient's medical treatment for the diagnoses listed above.

Physician Signature: _____ Date: _____

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.