**Referral for Medical Nutrition Therapy**

Patient Name: Male Female

Date of Birth: Phone Number:

Parent/Guardian Name(s) if minor:

Primary Insurance Co: Member ID

Secondary Insurance Co: Member ID

Applicable Diagnoses:

ICD-10 Dx Code / Description:

ICD-10 Dx Code / Description:

ICD-10 Dx Code / Description:

Please provide reason for referral and/ or other necessary details pertaining to this referral:

To assist in the care of your patient, please include the following (as applicable) with your referral:

* Recent lab results
* Current list of diagnoses / problems

Provider Signature: Date:

Printed Name:

Name of Practice:

NPI: Phone: Fax:

**Please fax all referrals and medical records to: 812-461-6999 (secure line)**

**Thank you!**