



Araceli Vázquez, MS, RD, LD

Adult Referral for Dietetic Counseling /Medical Nutrition Therapy (MNT)

Please attach current list of medications, dosages & current lab results.

Date:	Patient name:	Date of Birth: (mm/dd/yyyy)			
Day time phone numbers: (H) (Cell)		Health Plan: Medicare____ Private Insurance Name:	Subscriber ID# Group # or Attach copy of Insurance Card		
Patient Address:		Subscriber Name:	Height:	Weight:	Gender: Female____ Male____

Referral From: Clinic Name: _____ _____ Referring Physician/Provider Name: _____ Office Contact for this Referral: _____ Address: _____ City/State/Zip: _____ _____ Phone: _____ Fax: _____	Referral To: Araceli Vázquez, MS, RD, LD. 990 South Sherman St Richardson TX 75081 Phone: 972-664-0846 cell 972-822-0791 Fax: 972-744 0726
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****REASON FOR ORDERING Dietetic Counseling/ MNT** MEDICAL DIAGNOSES (check all that apply below)**
[Required in order to initiate MNT service]

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes type 1 or 2 (circle type) | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Hyperglycemia(High glucose and/or High HgA ₁ C) | <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Eating Disorder, Unspecified |
| <input type="checkbox"/> Crohn's disease NOS | <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Morbid Obesity |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Dysmetabolic Syndrome X |
| <input type="checkbox"/> Underweight/Uncontrolled weight loss | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Celiac Disease |
| <input type="checkbox"/> Uncontrolled Weight gain | <input type="checkbox"/> Hypertriglyceridemia | |

Other – please specify: _____ AND provide the date of diagnoses: _____

Relevant Medications and Dosages (type/frequency): _____

Relevant Lab Data:

(attach current lab data)

Physical Activity Restrictions: none: _____ limit to: _____

Comments (medical conditions, special instructions): _____

MNT is a necessary part of the patient's medical treatment for the medical diagnosis (es) listed above.

Physician's Signature _____ **Date** _____

NPI number: _____

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.