Araceli Vázquez, MS, RD, LD

Pediatric 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: Amerigroup___ Trad. Medicaid: _____ Molina Healthcare:_____ Other:_____ 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's 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**

****REASON FOR ORDERING Dietetic Counseling/ MNT** MEDICAL DIAGNOSES (check all that apply below)**
[Required in order to initiate MNT service)

___Diabetes type 1 or 2 (circle type)
___ Hyperglycemia (High glucose and/or High HgA_1C)
___ Hyperinsulinemia
___Hypertriglyceridemia
___ Failure to Thrive (FTT)
__Acanthosis Nigricans
___Pediatric Obesity
___Hyperlipidemia
____Hypercholesterolemia
___ Eating Disorder, unspecified
___ Underweight/Uncontrolled weight loss
___ Uncontrolled Weight Gain
___Overweight
___ Dysmetabolic Syndrome X

___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.