Priyanka S., Registered Dietitian Nutritionist, Licensed Dietitian; 2136 FORD PKWY #5285, St. Paul MN 55116 P: 612-756-9894;www.gingerspicehealth.com

Referral form for Medical Nutrition Therapy

Today's Date:_____ Patient Name _____ Patient DOB _____

Patient Phone _____ Insurance Company _____

(We believe in collaborating and teamwork for positive patient outcomes! **Please feel free to make multiple copies and use this blank referral form** anytime when you have a patient who could benefit from diet and nutrition counseling, for preventative or medical conditions. Let us take care of the rest! We help verifying nutrition benefits, schedule, and keep you informed of progress).

REQUESTING 1) **check off medical diagnosis in this form** 2) **recent progress note/recent labs/ medication list/ office visit summary/H&P** AND **demographic info.** One Step process:

Please **FAX #612-712-8264 or email Priyanka@gingerspicehealth.com**

Any specific diet patient is on/**diet order:**_____

Please circle, if applicable: **BMI<18.5 OR BMI>25/family hx CVD or elevated lipids, HT, prediabetes, any CVD risk factor/metabolic syndrome/diabetes**

	Morbid obesity d/t excess calories		Type 2 diabetes with _____
	Other obesity d/t excess calories Drug-induced obesity Overweight		Type 2 diabetes with other specified complications Type 2 diabetes without complications Long term (current) use of insulin
	Other obesity		Impaired fasting glucose
	Obesity, unspecified Abnormal weight gain - not pregnant		Prediabetes Gestational diabetes, _____ controlled
	Nonalcoholic steatohepatitis (NASH) Fatty (change of) liver, not classified		Excessive weight gain in pregnancy Obesity complicating pregnancy
	GERD_____		Essential (primary) hypertension
	Crohn's disease_____		Heart failure, unspecified
	Celiac disease		Metabolic syndrome
	Irritable bowel syndrome		Pure hypercholesterolemia, unspecified
	Constipation		Pure hyperglyceridemia
	Polycystic ovarian syndrome		Mixed hyperlipidemia
			Hyperlipidemia, unspecified
	Chronic kidney disease, stage _____		Malnutrition/mild
	Other: _____		Malnutrition/moderate:
	Other: _____		Other: _____

Physician Signature: _____ Physician Name (print): _____

Clinic Name:_____NPI Number: _____ Phone:_____Fax:_____

The above patient's information is Protected Health Information (PHI), and is the minimum necessary to execute 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 HIPPA. Insurances we accept in Minnesota: