

**Araceli Vázquez, MS, RD, LD**  
**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 number:	Health Plan: Primary _____ Secondary _____	Medical Record Number:		
Patient Address:	Subscriber Name:	Height:	Weight:	Gender: Female _____ Male _____
	Subscriber ID#      Group #			
<b>Requested service:</b> ___ Initial MNT                      ___ Follow-up MNT				

<b>Referral From:</b> Clinic Name: _____ Referring Physician/Provider Name: _____ Office Contact for this Referral: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____	<b>Referral To:</b> Araceli Vázquez, MS, RD, LD. 990 South Sherman St Richardson TX 75081 Phone: 972-664-0846 cell 972-822-0791 <b>Fax: 972-744 0726</b>
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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)<br><input type="checkbox"/> Crohn's disease NOS<br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> Unspecified disorder or lipid metabolism<br><input type="checkbox"/> Other – please specify: _____ | <input type="checkbox"/> Cardiovascular disease – list type: _____<br><input type="checkbox"/> Chronic kidney disease<br><input type="checkbox"/> Hyperlipidemia<br><input type="checkbox"/> Morbid obesity <input type="checkbox"/> Pediatric Obesity |
|---|--|
- AND provide the date of diagnoses: \_\_\_\_\_

**Relevant Medications and Dosages (type/frequency):** \_\_\_\_\_

**Relevant Lab Data:**  
*(attach current lab data)*

Date:	Lab value:
	BP:                      mm Hg
	glucose:                mg/dL
	HbA1c:                    %
	TC:                        mg/dL
	HDL:                      mg/dL
	LDL:                      mg/dL
	TG:                        g/dL
	BUN:                      mg/dL
	ALB:                      g/dL
	Creat:                     mg/dL

**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.