ALLIED NUTRITION CARE

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New Patient Referral Form

Patient Name: _____ **Patient Phone:** _____

Insurance: _____ **Date of Birth:** _____

- Please fax the most recent and relevant clinical information, progress note, and labs.
- Please check below all applicable reasons for referral. Write other diagnoses with ICD-10 codes.
- **Please note that <u>all services are virtual</u>, and we do not currently offer in-office visits.**

Digestive Health Concerns ___ K21.9 Reflux / GERD ___ K31.84 Gastroparesis ___ K50.90 Crohn's Disease, Unspecified ___ K51.90 Ulcerative Colitis, Unspecified ___ K58.9 Irritable Bowel Syndrome without Diarrhea ___ K58.0 Irritable Bowel Syndrome with Diarrhea ___ K58.1 Irritable Bowel Syndrome with Constipation ___ K76.0 Hepatic Steatosis ___ K90.0 Celiac Disease	**Other Diagnoses** ___ E78.00 Hypercholesterolemia ___ E78.1 Hypertriglyceridemia ___ E78.5 Hyperlipidemia, Unspecified ___ E88.819 Insulin Resistance, Unspecified ___ E88.81 Metabolic Syndrome ___ E28.2 Polycystic Ovarian Syndrome ___ E11.9 Diabetes, Type 2 ___ E10.9 Diabetes, Type 1 ___ R73.03 Pre-Diabetes
Nutrition Concerns ___ Z71.3 Dietary Counseling & Surveillance ___ Z72.4 Inappropriate Diet & Eating Behaviors ___ E63.9 Nutritional Deficiency, Unspecified ___ R63.4 Abnormal Weight Loss ___ N91.2 Amenorrhea, Unspecified ___ E44.0 Moderate Protein-Calorie Malnutrition ___ E44.1 Mild Protein-Calorie Malnutrition ___ E66.9 Obesity, Unspecified ___ E66.3 Overweight ___ R63.6 Underweight **Allied Nutrition Care does not support the use of BMI as a reliable indicator of health. At the same time, we may use diagnosis codes for "overweight" or "obesity" for insurance reimbursement purposes.*	**Eating Disorders** ___ F50.00 Anorexia Nervosa, Unspecified ___ F50.01 Anorexia Nervosa-Restricting Type ___ F50.02 Anorexia Nervosa-Binge/Purge Type ___ F50.2 Bulimia Nervosa ___ F50.81 Binge Eating Disorder ___ F50.89 Other Specified Eating Disorder ___ F50.9 Eating disorder, Unspecified **Other Diagnoses + ICD-10 Codes:** _____ _____ _____ _____

I am referring the above patient to Allied Nutrition Care LLC for nutritional assessment and medical nutrition therapy.

Provider First and Last Name: _____ **Clinic:** _____

NPI#: _____ **Phone:** _____ **Fax:** _____

Signature (required): _____ **Date:** _____