St. Clair County
Community Mental Health
Promoting Discovery & Recovery Opportunites for Healthy Minds & Bodies
(810) 985 8900

Physician Referral for Dietitian

Physician or Psychiatrist Name: _____ Specialty: _____

Individual: _____ Case #: _____ DOB: _____

Height: _____ Weight: _____

Reason for referral to dietitian (**diabetes or CKD must be checked** to qualify for MNT (Medical Nutrition Therapy)):

☐ E10.9 Type 1 Diabetes Mellitus - ***Without*** Complications
☐ E10.8 Type 1 Diabetes Mellitus - ***With Unspecified*** Complications

☐ E11.8 Type 2 Diabetes Mellitus - ***Without*** Complications
☐ E11.9 Type 2 Diabetes Mellitus - ***With Unspecified*** Complications

☐ R73.09 Pre-diabetes
☐ E66.9 Obesity, Unspecified Obesity NOS
☐ CKD (identify stage):

☐ N18.1 CKD Stage 1
☐ N18.2 CKD Stage 2
☐ N18.3 CKD Stage 3
☐ N18.4 CKD Stage 4
☐ N18.5 CKD Stage 5
☐ Z94.0 Kidney Transplant Status

☐ Other Diagnoses- Must include ICD-10 Code:

_____

_____

Pertinent Lab Data (or attach report):

☐ HgbA1C (please include if referral is for diabetes)
☐ Glucose
☐ Total Cholesterol
☐ Triglycerides
☐ Albumin

For Patients With CKD:

☐Creatinine
☐BUN
☐GFR
☐Ca
☐Phosphorus
☐Potassium

Current medications (or attach list):

_____

_____

List any diet or nutrition recommendations made to patient:

_____

_____

*The form **must** be signed by a **Physician or Psychiatrist** to qualify for MNT*

_____ _____

Physician / Psychiatrist Signature Date Time

Health-Medical Form: #04-0179
Reviewed Date: 7/1/2024
EHR: Health Services, Other Health Documents Note: InShape Physician Referral Form For Dietitian