



Health in Motion™

Medical Nutrition Therapy (MNT) Referral

CMC, LACC, MCLA and PASC-SEIU Members

Medical Nutrition Therapy consults for the listed common diagnoses are provided by Registered Dietitians over the telephone.

Instructions: ¹ All fields on this form must be completed, not doing so may delay care. Treating provider signature, relevant chart notes, medication list, labs and ICD-10 codes must be included. ² If a referral is faxed, the office must retain the faxed documents as part of the patient's medical record. ³ In lieu of using this form provider may e-fax an electronic order that includes the following: Request for RD consult, diagnosis, pertinent labs, medication list, notes, desired objective of treatment, clearance or restrictions for physical activity and treating/prescribing provider e-signature.

Member Information

Name: _____ Member Identification #: _____

Date of birth: _____ Language Spoken/Written: _____ / _____ Primary phone #: _____

Special Needs: Vision impaired Hearing impaired Cognitive/ Intellectual/ Developmental Disability Physical disability

Was member informed of referral? Yes date: _____ No

Primary Care Provider Information (MD, DO)

PCP Name: _____ Office/Medical Grp: _____

Address: _____

Phone # / Extension : _____ Fax #: _____

OBJECTIVE OF TREATMENT/NOTES Optimize treatment Other: _____

DIAGNOSIS

Diabetes MNT Type 1 Type 2

Gastrointestinal Disorder: _____

Hypertension

Hyperlipidemias/Hypercholesterolemia

Kidney Disease – CKD 1 to 4

Prediabetes (A1C 5.7 to 6.4%)

Pediatric (age 2-18) underweight (BMI < 5th %ile/age)

Pediatric (age 2-18) overweight (BMI > 85th-95th %ile/age)

Pediatric (age 2-18) obesity (BMI > 95th %ile/age)

Adult underweight (BMI <18.5 or <23 if >65 y/o)

Adult obesity (BMI 30+)

Other: _____

ICD-10 Codes:

Please submit relevant chart notes.

Medication(s) (list may be attached)

ANTHROPOMETRICS

Date Taken: _____ Ht: _____ Wt: _____ BMI: _____ Pediatrics: BMI-for-age-percentile _____ BP _____ / _____

LABORATORY WORK (include applicable labs, list may be attached, missing information may delay care)

A1C	FBG	LDL	HDL	TG	HCT/ HGB	Ua Micro Alb/Cr	BUN/ Cr	e-GRF	Na/K	Phos/PTH	Vit D	Other:

PHYSICAL ACTIVITY/EXERCISE

Cleared: May walk 20-30 mins 5-7 times/week or _____

Not cleared: _____

Treating provider signature X _____ (MD, DO, PA or NP)

Name: _____ Lic# _____ Date: _____

NOTE: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential or otherwise exempt from disclosure under applicable law. If you are not the intended recipient, or the employee or agent responsible for delivering this communication to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender and delete any copies. L.A. Care Health Plan, 1055 W. 7th Street, 10th Floor, Los Angeles, CA 90017, Tel: (213) 694.1250 Ref 2020/2/14

PLEASE FAX COMPLETED REFERRAL FORM TO 213.438.5042 | FOR QUESTIONS CALL 855.856.6943