L.A. Care

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 **ICD-10 Codes:**

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: _____ _____

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: _____