University Hospitals
Cleveland Medical Center

UHCMC Outpatient Clinical Nutrition

Medical Nutrition Therapy (MNT) Referral Form

PLEASE CALL TO SCHEDULE: (216) 844-1499; FAX: (216) 844-7013

Adult Nutrition Services Locations: UHCMC W.O. Walker, UHCMC Digestive Health Institute Bolwell 6, Chagrin Highlands Health Center, Ahuja Risman Pavillion, Landerbrook Health Center, Medina Health Center, Solon Health Center, or Westlake Health Center Digestive Health Institute

Patient's Name:_____ **Date:**_____
DOB:_____
Patient's Phone:_____
Medical Record Number: _____

DIAGNOSIS CODE/S (required)

__O__.__	Gestational Diabetes Mellitus_____		
__E__.__	Other Specified Diabetes Mellitus_____		
__R73.9	Hyperglycemia, UNS	__K58.0	Irritable bowel syndrome with diarrhea
__N18.9	Chronic Kidney Disease, unspecified	__K58.9	Irritable bowel syndrome without diarrhea
__N18.3	Chronic Kidney Disease Stage III	__K59.00	Constipation, unspecified
__N18.4	Chronic Kidney Disease Stage IV	__K31.84	Gastroparesis
__I10	Essential (primary) hypertension	__K21.0	Gastroesophageal reflux disease with esophagitis
__E78.00	Pure hypercholesterolemia, unspecified	__K21.9	Gastroesophageal reflux disease without esophagitis
__E78.1	Pure Hyperglyceridemia	__E66.01	Morbid (severe) obesity due to excess calories
__E78.2	Mixed Hyperlipidemia	__E66.09	Other obesity due to excess calories
__R63.4	Abnormal weight loss	__E66.1	Drug-induced obesity
__R63.6	Underweight	__E66.3	Overweight
__R62.7	Failure to thrive (adult)	__E66.8	Other obesity
__E46	Unspecified Protein Calorie Malnutrition	__E66.9	Obesity, unspecified
__E55.9	Vitamin D Deficiency, unspecified	__E88.81	Metabolic Syndrome
__K90.0	Celiac Disease	__R63.5	Abnormal weight gain
__K52.29	Allergic and dietetic gastroenteritis and colitis, other	__Z68.__	Body Mass Index (BMI)_____

****Other DX and ICD-10 Code/s (specify):** _____
_____

LABORATORY DATA

Wt: _____ Ht: _____ BMI: _____
Glomerular Filtration Rate (13-50 ml/min/1.73m$_2$): _____ OR Serum Creatinine: _____
Fasting Blood Glucose (≥ 126 mg/dl): _____ HgbA1c: _____
Total Cholesterol: _____ HDL: _____ LDL: _____
Triglycerides: _____ BP: _____ *Please attach any other labs if necessary

Reason for Referral:

_____ Weight Reduction Needed
_____ Weight Gain Needed
_____ Diabetes Medical Nutrition Therapy
_____ Other: _____
_____ Food Allergy: _____
_____ Low Cholesterol/Low Saturated Fat Diet
_____ Low Sodium Diet

If patient requires nutrition support, provide current feeding regimen

_____

****For Weight Loss Referrals--Clearance for Exercise Yes No (Circle One)**
Relevant Medications:_____

Print Physician's Name: _____
Physician's Phone/Fax: _____
Physician's Signature: _____ Date:_____

*Physician- retain original and fax a copy to the dietitian.