



CARUSO
PHYSICAL THERAPY
AND NUTRITION, LLC

1278 YARDVILLE-AlLENTOWN ROAD, SUITE 3, ALLENTOWN, NJ 08501
P: 609.738.3143 • F: 609.738.3144 • CARUSO@CARUSOPTRD.COM

MEDICAL NUTRITION THERAPY REFERRAL FORM

Patient Information

Date of Referral: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Health Insurance Company: _____

Phone Number: _____

Insurance ID#: _____

Reason for Referral

Please indicate all diagnoses related to this referral, along with the corresponding ICD -10 codes.

<input type="checkbox"/> E03.9 Hypothyroidism, unspec <input type="checkbox"/> E10.9 Type 1 Diabetes, w/o complications <input type="checkbox"/> E11.9 Type 2 Diabetes, w/o complications <input type="checkbox"/> E16.0 Hypoglycemia, drug induced <input type="checkbox"/> E43 Unspecified severe protein-calorie malnutrition <input type="checkbox"/> E66.0 Obesity due to excess calories <input type="checkbox"/> E66.3 Overweight due to endocrine, nutritional, and metabolic diseases <input type="checkbox"/> I51.9 Heart disease, unspec <input type="checkbox"/> I10 Uncontrolled hypertension, essential <input type="checkbox"/> K21.0 GERD with esophagitis	<input type="checkbox"/> K21.9 GERD without esophagitis <input type="checkbox"/> K29.60 Chronic Gastritis <input type="checkbox"/> K50.911 Crohn's disease, unspec <input type="checkbox"/> K57.30 Diverticulitis of large intestine w/o perforation or abscess w/o bleeding <input type="checkbox"/> K58.0 Irritable bowel syndrome w/ diarrhea <input type="checkbox"/> K59.0 Constipation, unspec <input type="checkbox"/> K75.81 Nonalcoholic steatohepatitis (NASH) <input type="checkbox"/> K86.1 Chronic pancreatitis <input type="checkbox"/> K90.0 Celiac disease <input type="checkbox"/> N18.0 Chronic kidney disease (CKD) <input type="checkbox"/> E78.5 Hyperlipidemia	<input type="checkbox"/> 024.210 Gestational diabetes mellitus in pregnancy <input type="checkbox"/> R63.0 Anorexia <input type="checkbox"/> R63.3 Feeding difficulties <input type="checkbox"/> R63.4 Abnormal weight loss <input type="checkbox"/> R63.5 Abnormal weight gain <input type="checkbox"/> R63.6 Underweight <input type="checkbox"/> R73.03 Prediabetes <input type="checkbox"/> Z82.49 Family history of ischemic heart disease and other diseases of the circulatory system <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
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This referral is for Medical Nutrition Therapy as part of medical treatment and prevention for the diagnoses listed above.

Provider's Name: _____

Provider's Signature: _____

Provider's NPI: _____

Please fax all referrals to:
F: 609.738.3144