Life Focus Nutrition Centers

14 Rye Ridge Plaza, suite 223
Rye Brook, New York 10573
NY Telephone (914)935-0123

Offices at

This does not replace required insurance referrals!
MD Please FAX FORM TO (866)293-4500
OR Email: LA@lifefocusnutrition.com

Linda Arpino, RDN, CDN

21 Craig Court
Stamford, CT 06903
CT Telephone (203) 321-8454

MD REFERRAL FORM for Medical Nutrition Therapy

Date:	Patient Name:	Date of Birth:
From: Linda Arpino, MA, RD, CDN	Sent via fax to: ( )	Physicians Name:
Height: Weight:	Waist Circumference:	Gender:

To Patients: Please complete the information above and give to your primary doctor.
I acknowledge and authorize release of information to health care provider/s listed above and give permission to share my pertinent medical information, lab tests and medication for my healthcare treatment.
Patient Signature_____ Date:_____

Directions for PHYSICIANS:
This form is required to coordinate services with our patient's physicians. Our office does not diagnose, we ask the treating physician to provide us with any medical diagnoses the patient named below including abnormal lab results and pertinent medications, if any. This form does not replace any insurance plan required referrals, so check with the plan. Please list diagnosis with the correct ICD 10 code. If there are any restrictions on physical activity please list or attach pertinent documentation. Thank you for completing this form. Linda

To Physicians please write below the primary and secondary Medical Diagnoses: You may ATTACH YOUR EMR FORM OR WRITE ALL DX CODES that apply below:

1) **Primary DX** _____ **ICD 10:**_____ **Additional Info:**
2) **Secondary DX**_____ **ICD 10:** _____
3) **DX**_____ **ICD10** _____
4) **DX**_____ **ICD10**_____

Relevant Medications and Dosages (type/frequency):

Relevant Lab Data or attach a copy:

Date	Lab value	
	BP:	mmHg
	Glucose:	mg/dL
	HbA1c:	%
	TC:	mg/dL
	HDL:	mg/dL
	LDL:	mg/dL
	TG:	g/dL
	BUN:	mg/dL
	ALB:	g/dL
	Creat:	mg/dL

MD Clearance for Patient to Engage in physical activity: Yes_____No__

MNT is a necessary part of the patient's medical treatment for the medical diagnosis(es).
Stamp or Print Physicians Name:_____

Physician's Signature_____**Date**_____
NPI#_____

The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments and Healthcare Operation Laws mandated by HIPAA.

Fax this form to (866)293-4500

Thank You!

Linda Arpino, RDN, CDN,FAND

Patient Directions: The primary doctor must complete the above information and fax this form to our office FAX#**(866)293-4500.**