Outpatient Medical Nutrition Therapy Center
7800 Sheridan Street Pembroke Pines, Fl 33024
Ph: (954) 883-8520 Fax: (954) 276-0366

Please call for an appointment and include current labs and referral/authorization, if applicable.

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Email: _____

Primary Insurance: _____ MRN: _____

☐ **Rx:** Outpatient Medical Nutrition Therapy (include all individualized nutrition therapy)

Diagnosis:

☐ Z71.3 General Nutrition ☐ E109 Type 1 ☐ E119 Type 2 ☐ E13.9 LADA
☐ E1069 Type 1 w/ complications ☐ E1169 Type 2 w/ complications ☐ N18.1 Stage 1 CKD
☐ N18.2 Stage 2 CKD ☐ N18.31 Stage 3a CKD ☐ N18.4 Stage 4 CKD ☐ N18.5 Stage 5 CKD
☐ R73.02 IGT/IFG ☐ E28.2 PCOS ☐ E88.81 Dysmetabolic Syndrome
☐ E78.00 Elevated Cholesterol ☐ E46 Malnutrition ☐ E66.9 Obesity/Weight loss
☐ 62.7/R62.51 Failure to Thrive ☐ I51.9 Heart Disease ☐ R73.09 Pre-Diabetes ☐ K92.9 GI Conditions
☐ Other (specify): _____

FOR MEDICARE PATIENTS ONLY

Please choose only one of the following services for Diabetes Education **OR** Medical Nutrition Therapy

☐ **Rx:** Diabetes Education (Includes Individualized Nutrition Therapy) Enter **Diagnosis** Code: _____
(Please specify the **number of hours** of Diabetes Education your patient needs **AND** whether you want the patient to have a group or individual education. If you check individual education, please specify why (Medicare Requirement)

My patient needs:

Total # of hours of education	**AND**	Group and/or Individual
☐10 hours of education (Maximum)	|	☐ Group: # of hours _____
☐ ___ hours of education	|	☐# of individual hours_____ Reason required: _____

Physician Name: _____MD/DO Phone #: _____

Physician Signature: _____ Date: _____