Life Focus Nutrition, LLC

Linda Arpino, RDN, CDN, FAND

Offices at

14 Rye Ridge Plaza, suite 230
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Stamford, CT 06903
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This does not replace required insurance referrals!

MD Please FAX FORM TO (866)293-4500

OR Email: LA@lifefocusnutrition.com

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:		Gender:

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.
Adult Patient/Legal Guardian's 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:

MNT is a necessary part of the patient's medical treatment for the medical diagnosis(es):

1) **Primary DX _____ ICD 10:_____** **If relevant attach: Pediatrics Weight Curve**
2) **Secondary DX_____ ICD 10: _____**
3) **DX_____ ICD10 _____** **Additional Information:**
4) **DX_____ ICD10_____**

Please Include RX 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
	Vit. D	

MD Clearance for Patient to Engage in physical activity: Yes_____No_____
Stamp or write Physicians Name and office address (here)

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