Memorial Hospital
OF SWEETWATER COUNTY

MEDICAL NUTRITION THERAPY REFERRAL & PHYSICIAN ORDER FORM

PATIENT INFORMATION

Patient Name: DOB:

Address:

Home Phone: Alternate Phone:

MEDICAL INFORMATION

Diagnosis:

Medical History/Complications: Ht: Wt:

Medications:

Special Considerations: ☐ Visual ☐ Hearing ☐ Language ☐ Physical Disabilities

Laboratory Data: *please fill in pertinent data below or attach report*

Date:		Result:	Date:		Result:
	HbA1C			BUN	
	Fasting Glucose			Creatinine	
	Cholesterol			Albumin	
	HDL			Potassium	
	LDL			Phosphorus	
	Triglycerides			Other:_____	

EDUCATION PLAN

PLEASE INDICATE DESIRED PLAN OF CARE:

☐ Diabetes Self Management Education Program (DSME)

☐ Medical Nutrition Therapy (MNT)

- ☐ General Nutrition
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Diabetes
- ☐ Healthy Heart
- ☐ Sodium Restriction
- ☐ Renal Diet - *please check all that apply*
  - ☐ Low Protein
  - ☐ Low Sodium
  - ☐ Low Potassium
  - ☐ Low Phosphorus
  - ☐ Fluid Restriction
- ☐ Food Allergies *please list* _____
- ☐ Other: _____

_____ _____

Primary Care Physician/PA/NP Date

Signature must be hand signed - Medicare will not accept stamped signature

Please Fax to Outpatient Nutrition Services at 307-352-8122