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**My Signature Nutrition, LLC**  
Sara Upson, M.Ed, RD, LD

Instructions: Complete this form and fax to My Signature Nutrition, LLC 903.561.8799. Please have the patient call My Signature Nutrition, LLC 903.312.8906 to schedule an appointment. Give the original form to the patient to bring to their appointment. Please call with questions or to coordinate care.

**Medical Nutrition Therapy (MNT) Referral Form**  
Please fax to: 903.561.8799

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_

Reason for MNT Referral:  
\_\_\_\_\_

*Note:* Please send pertinent labs, H&P, and other supporting documentation of diagnoses.

**Common MNT Diagnostic Codes (ICD-9)**

(ICD-9 codes are for your convenience, please alter/ change as needed & check all that apply below.)

- |  |        |  |        |
|--|--------|--|--------|
| <input type="checkbox"/> Abnormal Weight Gain    | 783.1  | <input type="checkbox"/> Eating Disorder, NOS        | 307.50 |
| <input type="checkbox"/> Abnormal Weight Loss    | 783.2  | <input type="checkbox"/> Failure to Thrive, Adult    | 783.7  |
| <input type="checkbox"/> Amenorrhea              | 626.0  | <input type="checkbox"/> Gastroesophageal Reflux     | 530.1  |
| <input type="checkbox"/> Anemia                  | 285.9  | <input type="checkbox"/> Glucose Intolerance         | 271.9  |
| <input type="checkbox"/> Anemia, Iron Deficiency | 280.9  | <input type="checkbox"/> Hypercholesterolemia        | 272.0  |
| <input type="checkbox"/> Anorexia                | 783.0  | <input type="checkbox"/> Hyperlipidemia, NOS         | 272.4  |
| <input type="checkbox"/> Anorexia Nervosa        | 307.1  | <input type="checkbox"/> Hypertension, Essential     | 401    |
| <input type="checkbox"/> Bulimia Nervosa         | 307.51 | <input type="checkbox"/> Hypoglycemia                | 251.2  |
| <input type="checkbox"/> Cardiovascular Disease  | 429.2  | <input type="checkbox"/> Irritable bowel syndrome    | 564.1  |
| <input type="checkbox"/> Celiac Disease          | 579.0  | <input type="checkbox"/> Malnutrition, Mild          | 263.1  |
| <input type="checkbox"/> Constipation            | 564.0  | <input type="checkbox"/> Malnutrition, Moderate      | 263.0  |
| <input type="checkbox"/> Crohn's Disease         | 555.9  | <input type="checkbox"/> Nausea/Vomiting             | 787.0  |
| <input type="checkbox"/> Dehydration             | 276.5  | <input type="checkbox"/> Nutritional Deficiency      | 269.9  |
| <input type="checkbox"/> Diabetes, Type I        | 250.01 | <input type="checkbox"/> Obesity                     | 278.0  |
| <input type="checkbox"/> Diabetes, Type II       | 250.00 | <input type="checkbox"/> Osteoporosis                | 733.0  |
| <input type="checkbox"/> Diabetes, Gestational   | 648.8  | <input type="checkbox"/> Polycystic Ovarian Syndrome | 256.4  |
| <input type="checkbox"/> Diarrhea                | 787.91 | <input type="checkbox"/> Other                       | _____  |

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Group/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_