REFERRAL FORM FOR MEDICAL NUTRITION THERAPY

The Intuitive Eating Center of Ohio

FAX REFERRAL FORM TO 216-373-1409
OFFICE PHONE NUMBER: 216-395-4118
WWW.INTUITIVEOHIO.COM

CLIENT INFORMATION

Client Name _____

Date of Birth ____ /____ /____

Insurance Company _____

Member ID _____

Home Address _____

City _____ Zip Code _____

Phone Number _____ Email _____

REFERRING CLINICIAN INFORMATION

Name _____ NPI _____

Phone Number _____ Fax Number _____

REQUIRED: CHECK BOX FOR REASON(S) FOR REFERRAL

- ◯ F50.01 Anorexia nervosa, restricting type (select severity below)
  - ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme ◯ In Remission
- ◯ F50.02 Anorexia nervosa, binge eating/purging type (select severity below)
  - ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme ◯ In Remission
- ◯ F50.2 Bulimia nervosa (select severity below)
  - ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme ◯ In Remission
- ◯ F50.81 Binge Eating Disorder (select severity below)
  - ◯ Mild ◯ Moderate ◯ Severe ◯ Extreme ◯ In Remission
- ◯ F50.82 Avoidant/Restrictive Food Intake Disorder (ARFID)
- ◯ F50.89 Other Specified Eating Disorder (OSFED)
- ◯ E11.9 Type 2 Diabetes
- ◯ E78.5 Hyperlipidemia
- ◯ I10 Hypertension
- ◯ Other _____

PLEASE ATTACH PATIENT COVER SHEET WITH REFERRAL. INCLUDE CLIENT'S DOB, INSURANCE INFORMATION, AND PERTINENT HISTORY AND/OR LABS.

Physician Signature _____ Date ____ /____ /____