



Teamwork Nutrition and Consulting, LLC

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Website: www.teamworknutrition.com

Patient Information:

Full Name:	Click or tap here to enter text.
Date of Birth:	Click or tap here to enter text.
Phone Number:	Click or tap here to enter text.
Email Address (optional):	Click or tap here to enter text.

Reason for Referral (*check all that apply*):

<input type="checkbox"/> Weight Management- Loss	<input type="checkbox"/> Weight Management- Gain
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol / Triglycerides
<input type="checkbox"/> Prediabetes / Diabetes	<input type="checkbox"/> Gastrointestinal Issues
<input type="checkbox"/> Sports / Performance Nutrition	<input type="checkbox"/> Other: Click or tap here to enter text.

Diagnosis with ICD-10 Code (*required for MNT referrals*):

Diagnosis(es):	Click or tap here to enter text.
ICD-10 Code(s):	Click or tap here to enter text.

Referral Type (*choose one – for insurance and billing purposes*):

<input type="checkbox"/> Preventive – No diagnosis required (e.g., general wellness, healthy eating, weight loss, sports nutrition). Typically billed under Z71.3 (Dietary counseling and surveillance).
<input type="checkbox"/> Medical Nutrition Therapy (MNT) – Requires medical diagnosis and ICD-10 code (e.g., diabetes, obesity, hypertension). Appropriate for chronic conditions requiring nutrition intervention.

Referring Provider Information:

Provider Name:	Click or tap here to enter text.
Practice / Clinic Name:	Click or tap here to enter text.
Phone Number:	Click or tap here to enter text.
Provider NPI Number:	Click or tap here to enter text.
Provider Signature (<i>typed, drawn, or image OK</i>):	Click or tap here to enter text.
Date:	Click or tap to enter a date.

Submit: Fax to **804-773-3552** or email securely to referrals@teamworknutrition.com

Thank you for your referral.