Sound Dietitians LLC
Phone: 425-409-3544
Fax: 425-354-3544
Office@SoundDietitians.com

Date:	Patient name:
Day time phone number:	Insurance: (Attach copy of front & back of card)
DOB:	Home address:

Referral is for Medical Nutrition Therapy as a necessary part of medical treatment and prevention of complications for diagnoses listed.

Referral Needs: New Diagnosis New treatment plan

Special Needs: Language Hearing/Speech/Vision

Other:

☑ Check all diagnoses that apply to this referral

☑	ICD-10	ICD-10 Description	☑	ICD-10	ICD-10 Description

Lab work (Please attach or complete) BP _____/ _____

Hct/ Hgb	FBS &/or PC	Hgb A1c	Total Chol	HDL / LDL	Non HDL	Trig	Ua Micro Albumin/Cr	BUN/ Cr	EGFR	Na/K	Phos/ PTH	Vit D

☐ Exercise/Activity Plan

Released: may walk 20-30 min 5-7 x/week or

Not Released:

Medications – Please attach list

☐ Physician signature X	MD/DO Phone:
NPI: Fax:	Print MD/DO Name:

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.