



Please fax your referral form to: 855-710-7869 For customer support please call 1855-481-1149

# H-E-B Nutrition Services Physician Referral Form for Medical Nutrition Therapy

Date: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_

Fax #: \_\_\_\_\_ Office #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

**\*\*\*Required\*\*\***

**Please check box for Primary Reason(s) for Referral:**

- E11.9 Type 2 DM
- E10.9 Type 1 DM
- E28.2 PCOS
- E78.5 Hyperlipidemia
- E66.0 Obesity
- R68.1 Underweight
- E66.01 Morbid Obesity
- E66.3 Overweight
- Z71.3 Preventative Care
- Other:

**Please include patient's cover sheet (DOB, Insurance Information) with referral**

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

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