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: _____