



Brunswick County Health Services

25 Courthouse Dr. NE; PO Box 9
Bolivia, NC 28422
(910) 253-2250 1-888-428-4429



David G. Howard, MPH, Director

MEDICAL NUTRITION THERAPY (MNT) / MEDICAL LACTATION (IBCLC) REFERRAL FORM

Patient Information:

Patient Name: _____ Date of Birth: _____ Sex: Male Female

Parent(s)/Guardian/Support Person Name: _____

Patient Address: _____

Primary Phone: _____ Alternate Phone: _____

Language Barriers/Interpreter Needed: _____

Insurance Information: Private Medicaid Medicare* None

Name of Insurance: _____ Insurance Number: _____

Insurance Authorization Required? Yes No Insurance Authorization Number: _____

ICD-10 / Diagnosis:

Dx 1. _____ Dx 2. _____ Dx 3. _____

Additional Information:

Please send two most recent medical notes to include ht./wt. and two most recent pertinent lab results with this referral.

I hereby certify that I have seen the beneficiary and assessed his/her medical condition(s) that are requiring medical nutrition therapy to improve the patient's quality of life and that the above prescribed training is a necessary part of management.

Provider's Printed Name: _____ NPI: _____

Provider's Signature: _____ Date: _____

Medical Doctor Doctor of Osteopathic Medicine

***Medicare requires MNT orders to be provided by a physician or MD/DO specialist.**

Practice Name /Address/Phone: _____