Bordeaux Nutrition®, LLC
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Medical Nutrition Therapy (MNT)
860-757-3474
66 Cedar Street, Suite 305
Newington, CT 06111

✓ **Please fax to 860-523-0141 or email to info@bordeauxnutrition.com before giving to patient. Thank you.**

Patient Name _____DOB_____Phone_____

Insurance Carrier _____ Member ID#_____

Medical Nutrition Therapy (MNT) prescribed for:

- ☐ Acanthosis nigricans
- ☐ ADD
- ☐ ADHD
- ☐ Allergies- Food Related
- ☐ Amenorrhea
- ☐ Anemia, Nutr.
- ☐ Anorexia
- ☐ Anorexia Nervosa
- ☐ Anxiety
- ☐ ASCVD
- ☐ Asthma
- ☐ Autism
- ☐ Back Pain/Ache
- ☐ Bulimia
- ☐ Cancer type_____
- ☐ Candidiasis
- ☐ Celiac
- ☐ CFS
- ☐ CHF
- ☐ Cholelithiasis
- ☐ Cirrhosis
- ☐ Colitis/Ileitis
- ☐ Constipation
- ☐ COPD
- ☐ CKD
- ☐ Crohn's Disease
- ☐ CVA
- ☐ Dehydration
- ☐ Dental Caries
- ☐ Depression
- ☐ Diabetes (IDDM)
- ☐ Diabetes (NIDDM)
- ☐ Diabetes, Gestational
- ☐ Diarrhea
- ☐ Diverticulosis
- ☐ Dizziness/light-headed
- ☐ Dysmenorrhea
- ☐ Dyspepsia
- ☐ Dysphagia Diet
- ☐ Eczema
- ☐ Edema
- ☐ Eating D/O, NOS
- ☐ ESRD, non-dialysis
- ☐ Failure to Thrive
- ☐ Family Hx_____
- ☐ Feeding difficulties
- ☐ Feeding prob. newborn
- ☐ Fibromyalgia
- ☐ Gastritis
- ☐ GERD
- ☐ Gout
- ☐ Headache
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia, Hiatal
- ☐ HIV
- ☐ Hyperemesis, Grav.
- ☐ Hyperglycemia
- ☐ Hyperinsulinism
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Hypothyroidism
- ☐ Interstitial Cystitis
- ☐ Irritable Bowel
- ☐ Lactose Intolerance
- ☐ Malabsorption Syndrome
- ☐ Malaise/Fatigue
- ☐ Malnutrition
- ☐ Menopausal
- ☐ Metabolic Syndrome
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ NASH
- ☐ Nausea/Vomiting
- ☐ Nephritis
- ☐ Nephrotic Syndrome
- ☐ Nutr Deficiency_____
- ☐ Obesity
- ☐ Obesity, pregnancy
- ☐ Osteoarthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Overweight (BMI >25)
- ☐ Otitis Media
- ☐ Pancreatitis
- ☐ PCOS
- ☐ PKU
- ☐ PMS
- ☐ Poor nutrition
- ☐ Pre-DM
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Steatorrhea
- ☐ Thrush
- ☐ TIA
- ☐ Ulcer
- ☐ Underweight
- ☐ Vaginitis
- ☐ Weight Gain, Abnormal
- ☐ Weight Loss, Abnormal
- ☐ Other _____

Pertinent Information:_____

Provider Name_____**NPI**_____**Phone**_____

Signature_____**Date**_____