Steps to initiate a referral for MNT:

1. Complete Aliveness membership application *(if not yet a member)*
2. Complete attached forms (see checklist below)
3. Submit forms via fax (612-822-9668) or secure e-mail (laurah@aliveness.org)

Forms checklist:

- Aliveness member application* (if not yet a member)
- Referral form (1 page)
- Screening form (2 pages)
- Signed and dated ROI (Aliveness ↔ Case Management Agency)
- Signed and dated ROI (Aliveness ↔ HIV Clinic)


Follow up from the dietician will be based on level of nutritional risk:

*High risk:* Client contacted by the RD within 1 week & followed every 1-3 months  
*Moderate risk:* Client contacted by the RD within 2 weeks & followed at least semi-annually  
*Low risk:* Client contacted by the RD within a month and followed at least annually

TIPS:

- The individual submitting this referral should be knowledgeable of the patient’s current medical condition, have access to the client’s medical record, and have recently met with the client.
- Portions of the screen may be done by or with other providers involved in the client’s care and/or the client themselves.
- The client’s care team is encouraged to respond promptly to any requests for additional information for timely initiation of the MNT process.
- Store a copy of these forms in the client's case management chart or medical chart.
Referral for Medical Nutrition Therapy (MNT)

Client Name: __________________________ Date of Birth: ____________

Aliveness member number (if known): __________

Contact Information (Phone/Email): ________________________________

Okay to leave a voicemail?  YES or NO

Name of HIV care provider and clinic: ________________________________

Date of last HIV appointment: ____________

Date of next HIV appointment, if scheduled: ____________

AbsCD4: _______ Date taken: _______ VL: _______ Date taken: _______

Primary reason(s) for MNT referral:  
☐ Mom’s Meals
☐ Liquid supplement (e.g. Ensure)
☐ Other __________________________

Preferred pharmacy: __________________________ Phone: ____________

Case Manager: __________________________ Phone: ____________

Name of referring provider (if not case manager listed above): ____________

Today’s date: ____________

For internal use:

Date referral received by RD: ____________

Positive screen for FI:  NO YES (Follow-up action taken: ___________________________)

Date of 1st attempt to contact client: __________ Date of 2nd attempt to contact client: __________

Notes: ___________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
Information about the client’s health picture is necessary to initiate MNT. Below is a list of information commonly needed for nutrition assessment. Please fill out to the best of your ability, and don’t forget signed ROI from clinic!

**Food/Nutrition-Related History**

Diet order/instruction (if applicable)_________________________________________________

Medications (dose, frequency) *(May attach list)*
________________________________________________________________________________________
________________________________________________________________________________________

Dietary/herbal supplements___________________________________________________________________

Physical Activity Restrictions: None: ______ Limit to: ________________

<table>
<thead>
<tr>
<th>How often are the following statements true? (circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the past 12 months I worried whether our food would run out before we got money to buy more.</td>
</tr>
<tr>
<td>Within the past 12 months the food I bought just didn’t last and I didn’t have money to get more.</td>
</tr>
<tr>
<td>Within the past 12 months I was unable to access enough food due to decreased mobility (lack of transportation, homebound, etc.)</td>
</tr>
</tbody>
</table>

**Anthropometric Measurements (ADULTS)**

Height ____________ □ Measured □ Stated        Weight (lb or kg) ___________ □ Measured □ Stated

Usual Body Weight (UBW)__________

Target Weight ____________ Ever at target weight?  NO   or   YES (year______)

Weight change (lb/kg) ↑ ________ ↓ ________ In what timeframe ________________

☐ Intentional   ☐ Unintentional   ☐ Gestational

**Biochemical Data, Medical Tests and Procedures**

*Please attach most current dated lab data available including but not limited to:*

- HIV-related labs (absCD4, VL)
- Vital signs
- Electrolyte and renal profile
- Gastrointestinal profile (LFTs, etc.)
- Glucose/endocrine profile
- Inflammatory profile
- Mineral profile
- Nutritional anemia profile
- Protein profile
- Urine profile
- Vitamin profile
**Nutrition-focused Physical Findings**

Subjective notes on overall appearance, including any characteristics associated with pathophysiological states:

________________________________________________________________________________________
________________________________________________________________________________________

**Client History**

Medical/health history:

HIV and/or AIDS diagnosis and dates: ____________________

Current/recent opportunistic infections/acute illness: ___________________________________

Wasting diagnosis?    YES     NO

Co-morbidities (circle all that apply):

- Diabetes
- Kidney disease (on dialysis? YES NO)
- Cardiovascular disease (CVD)
- High blood pressure
- High cholesterol or triglycerides
- Cancer (type ________________)
- Liver disease (ex: hepatitis C)
- Osteoporosis/bone disease
- Anemia (low iron status)
- Other ________________

Other medical diagnoses and/or conditions (e.g., pregnancy): __________________________________________

Gastrointestinal/Oral problems (circle all that apply):

- Nausea or Vomiting
- Frequent/chronic diarrhea
- Constipation
- Poor Appetite
- Heartburn or GERD (painful, burning feeling in chest that radiates toward the neck/back)
- Indigestion (uncomfortable fullness during or after a meal, and burning or pain in the upper abdomen)

- Difficulty chewing
- Difficulty swallowing
- Other ________________

Other (socio-cultural information (e.g. primary language if not English), health literacy, best times to contact, etc.):

________________________________________________________________________________________
________________________________________________________________________________________

Today’s date: _______________

Print name of person completing this form: _________________________________________________

Signature of person completing this form: _________________________________________________

Relationship to client: □ CASE MANAGER □ HEALTHCARE PROVIDER □ SELF □ OTHER ______________
