# Referral for Medical Nutrition Therapy

## Patient Information

| | | | |
|---|---|---|---|
| Name | | MRN | |
| DOB | | Gender | |
| Phone 1 | | Phone 2 | |
| Address (Street, City, State) | | | |
| Email | | | |
| Preferred Language | Verbal: | Written: | |

## Services Requested

- ◯ Initial MNT
- ◯ Annual follow-up
- ◯ Additional MNT in the same calendar year

Number of additional hours

Please explain change in medical condition, treatment, and/or diagnosis

### Additional Instruction Requested

Glucose monitoring instruction

- ☐ Glucometer
- ☐ CGM

type clinic code

Insulin/injectable instruction

- ☐ Single/Multiple daily injections
- ☐ Insulin pump

type

Medicare coverage of MNT *requires* the referring physician to provide documentation of a diagnosis of diabetes based on *one of the following*:

A - Fasting blood sugar ≥ 126mg/dL on 2 different occasions B - 2 hour post-glucose challenge ≥ 200mg/dL on 2 different occasions

C - Random glucose test > 200mg/dL for a person with symptoms of uncontrolled diabetes

Specify at least one:

A)

| | | | Date |
|---|---|---|---|
| FBG | | mg/dL | |
| FBG | | mg/dL | |

B)

| | | | Date |
|---|---|---|---|
| 2 hr glucose challenge | | mg/dL | |
| 2 hr glucose challenge | | mg/dL | |

C)

| | | | Date |
|---|---|---|---|
| Random glucose | | mg/dL | |

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## Diagnosis ICD-10

Diabetes Type 1:

- ☐ E10.1 with ketoacidosis
- ☐ E10.2 with kidney complications
- ☐ E10.3 with opthalmic complications
- ☐ E10.4 with neurological complications
- ☐ E10.5 with circulatory complications
- ☐ E10.6 with other specified complications
- ☐ E10.64 with hypoglycemia
- ☐ E10.65 with hyperglycemia
- ☐ E10.8 with unspecified complications
- ☐ E10.9 without complications

Other

Diabetes Type 2:

- ☐ E11.1 with hyperosmolarity
- ☐ E11.2 with kidney complications
- ☐ E11.3 with opthalmic complications
- ☐ E11.4 with neurological complications
- ☐ E11.5 with circulatory complications
- ☐ E11.6 with other specified complications
- ☐ E11.64 with hypoglycemia
- ☐ E11.65 with hyperglycemia
- ☐ E11.8 with unspecified complications
- ☐ E11.9 without complications

Other

Diabetes Other:

## Laboratory Values (indicate below or attach)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Height | | Weight | | Fasting C-peptide | | ALT | |
| BP | | A1C | | GFR (for CKD attach relevant labs) | | AST | |

Has patient been tested for AABs ○ Y ○ N ☐ ICA ☐ IAA ☐ GADA ☐ IA-2A ☐ IA-2ßA ☐ ZnT8A

Other autoimmune disorders

Comorbidities/complications

Current diabetes medications dosage and frequency

History of bariatric surgery ○ Y ○ N Previous medical nutrition therapy ○ Y ○ N

I certify that I am managing this patient's diabetes and that the MNT ordered is medically necessary.

Physician signature: X _____ Date:

Print Physician Name: _____ NPI:

Group Practice Name: _____ Phone:

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