

Referral for Medical Nutrition Therapy

Patient Name:	Best Phone Contact:
Patient Address:	City: State: Zip:
Alternate Phone Contact:	Relationship to Patient:
Patient SS #:	Date of Birth:
Health Insurance and ID #:	Insurance Phone #:

Please fax insurance card when available

As the health care provider treating this beneficiary's diabetes, I certify that medical nutrition therapy (individualized meal plan) is needed under a comprehensive plan for this patient's diabetes care to ensure therapy compliance and/or to provide the necessary skills and knowledge to enable the patient to manage his/her condition.

<p>REASON FOR ORDERING TRAINING</p> <p><input type="checkbox"/> Fasting blood glucose \geq 126 mg/dL (one value only)</p> <p><input type="checkbox"/> Two-hour post glucose challenge test of \geq 200 mg/dL on two tests</p> <p><input type="checkbox"/> Kidney Disease</p>	<p style="text-align: center;">DIAGNOSIS AND TREATMENT PLAN</p> <p><input type="checkbox"/> 250.00 type 2 w/o complications</p> <p><input type="checkbox"/> 250.02 type 2, uncontrolled</p> <p><input type="checkbox"/> 250.01 type 1 w/o complications</p> <p><input type="checkbox"/> 250.03 type 1, uncontrolled</p> <p><input type="checkbox"/> 790.21 Impaired Fasting Glucose</p> <p><input type="checkbox"/> 277.7 Metabolic Syndrome</p> <p><input type="checkbox"/> Other Dx and Code: _____</p>
<p style="text-align: center;">TRAINING ORDERED</p> <p><input type="checkbox"/> Initial Medical Nutrition Therapy (3 hrs allowed in first calendar year)</p> <p><input type="checkbox"/> Follow-up Medical Nutrition Therapy (2 hrs each year after initial year)</p> <p><input type="checkbox"/> Reactive Hypoglycemia</p> <p><input type="checkbox"/> Metabolic Syndrome</p> <p><input type="checkbox"/> Other _____</p>	<p>Diabetes treated with:</p> <p><input type="checkbox"/> Diet only <input type="checkbox"/> Oral Medication <input type="checkbox"/> Insulin <input type="checkbox"/> Insulin Pump</p> <p style="text-align: center;">SPECIAL NEEDS FOR INSTRUCTION</p> <p>This patient cannot effectively participate in group instruction because of the following special needs:</p> <p><input type="checkbox"/> Language Barrier _____</p> <p><input type="checkbox"/> Impaired Vision/Hearing _____</p> <p><input type="checkbox"/> Other _____</p>

LABWORK (Please fax results and provide dates)	A1c:	Blood Pressure:	Urine Microalbumin:
Total Cholesterol:	Triglycerides:	HDL:	LDL:

Other comorbidities: Hypertension Peripheral vascular disease Neuropathy ESRD
 Other _____

SIGNATURE: MUST BE HANDSIGNED-STAMPS PROHIBITED BY MEDICARE

Referring provider's signature:	Provider UPIN:
Referring provider's name (printed):	Office Phone Number/Fax: