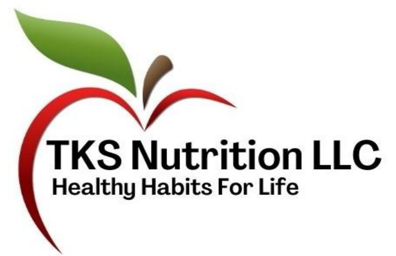
Physician Referral for Medical Nutrition Therapy



Phone: (302) 897-2088 ♦ Fax: (302) 376-9261
tsinibaldi@tksnutrition.com ♦ www.tksnutrition.com
244 Manchester Way, Middletown, DE 19709

Patient Information:

Patient Name: ______________________________ DOB: ______________
Home #: ______________ Cell #: ______________ Email: ______________________
Address: ____
Insurance Name: ______________________ Plan/Group #: ______________________

Physician Order: **Registered Dietitian to assess and provide Medical Nutrition Therapy (MNT)**

- ✓ Initial MNT (CPT code 97802)
- ✓ Follow-Up MNT (CPT code 97803)
- ☐ Additional MNT services in the same calendar year (Please specify change in diagnosis, medical condition or treatment regimen): ______________________________

Diagnosis: **Check diagnosis or add other diagnosed disease/ condition code**

Please send with referral: office notes, weight history, medication list and lab work

☐ Abnormal weight gain R63.5	☐ Diabetes, Type 2 **SPECIFY TYPE** E11.____________	☐ Hypoglycemia, **SPECIFY TYPE** E16.A1 **OR** A2 **OR** A3
☐ Abnormal weight loss R63.4	☐ Diabetes, Gestational **SPECIFY TYPE** O24.____________	☐ Hypothyroidism, unspecified E03.9
☐ Anemia D64.9	☐ Diabetes, Type 1 w/ pregnancy **SPECIFY TYPE** O24.__________	☐ Irritable Bowel Syndrome, diarrhea K58.0
☐ Anemia, Iron Deficiency D50.9	☐ Diabetes, Type 2 w/ pregnancy **SPECIFY TYPE** O24.__________	☐ Irritable Bowel Syndrome, constipation K58.1
☐ Anorexia R63.0	☐ Diabetes, Pre R73.03	☐ Irritable Bowel Syndrome, mixed K58.2
☐ Celiac Disease K90.0	☐ Diarrhea K59.1	☐ Malnutrition- Protein/calorie, moderate E44.0
☐ CKD Stage 1 N18.1	☐ Diverticulosis: specify type: K57. ________	☐ Malnutrition- protein/calorie mild E44.1
☐ CKD Stage 2 N18.2	☐ Diverticulitis: specify type: K57.________	☐ Malnutrition – protein/calorie unspecified E46
☐ CKD Stage 3a N18.31	☐ Failure to Thrive, Adult R62.7	☐ Metabolic Syndrome E88.81
☐ CKD Stage 3b N18.32	☐ Food Allergy K52.2	☐ Morbid Obesity E66.01
☐ CKD Stage 4 N18.4	☐ GERD, esophagitis K21.0	☐ Obesity Class 1 OR 2 OR 3 **SPECIFY TYPE** E66.811 **OR** E66.812 **OR** E66.813
☐ CKD Stage 5 N18.5	☐ Hypercholesterolemia E78.00	☐ Obesity, unspecified E66.9
☐ Constipation, unspecified K59.00	☐ Hypertriglyceridemia E78.1	☐ Overweight E66.3
☐ Crohn's Disease: **SPECIFY TYPE** K50.____	☐ Hyperlipidemia, mixed E78.2	☐ Polycystic Ovary Syndrome E28.2
☐ Diabetes, Type 1 **SPECIFY TYPE** E10.____________________	☐ Hypertension, essential I10	☐ Underweight R63.6 ☐ Other: ______________________

MEDICARE MEDICAL NUTRITION THERAPY ELIGIBILITY CRITERIA:

Must provide ONE of these diabetes diagnostic criteria (date and value)

- FBG lab ≥126 mg/dl on 2 tests: FBG:__________ and FBG:__________
- 2 hr OGTT lab ≥200 mg/dl on 2 tests: 2 hr OGTT:________ and 2 hr OGTT:________
- Random BG lab ≥200 mg/dl with symptoms of uncontrolled diabetes: Random BG:__________
  ☐ excessive thirst ☐ excessive urination ☐ excessive hunger ☐ blurry vision ☐ excessive tiredness ☐ unintentional wt loss
  ☐ tingling in extremities ☐ other:________________

For MEDICARE Renal MNT (date and value)

- GFR lab:______________________________ (note: 13 to 50 required for Medicare eligibility)

I hereby certify that I am treating this patient for the above diagnosis and that the prescribed medical nutrition therapy is a necessary part of the patient's medical treatment.

Physician Signature: ______________________________ **Date:** ______________
Printed Physician Name: ______________________________ **NPI #:** ______________
Office Phone #: ______________________________ **Fax #:** ______________