

## Medical Nutrition Therapy Referral

Phone: (808) 485-4327 Fax: (808) 485-4621

**Please attach the following with this referral:**

- Recent physician clinical notes pertaining to referral
- Lab reports x 2
- Copy of Insurance
- Copy of Patient Demographics

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Insurance: \_\_\_\_\_

Patient's preferred contact phone number(s): \_\_\_\_\_

### I. Patient with Diabetes:

- Newly diagnosed
- Known diabetes

**Diagnosis and ICD-10 Code(s):** \_\_\_\_\_

**\*Diagnostic criteria for diabetes: One of the following must be present:**

- Hemoglobin A1c  $\geq 6.5\%$  OR FBS  $\geq 126$  mg/dl
- Casual glucose  $> 200$  with symptoms of diabetes
- 2 hour OGTT  $\geq 200$  mg/dl

*\*In the absence of unequivocal hyperglycemia, these tests should be repeated another day.*

### II. Patient with Other Diagnosis/Reasons:

**Please select diagnosis:**

- Obesity/Morbid Obesity
- Hypertension
- Hyperlipidemia
- Renal / Kidney Disease
- Other (please specify and enter code)

**ICD-10 Code(s):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the Medical Nutrition Therapy requested is medically necessary under a comprehensive plan for this patient's care.

Print Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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