APPALACHIAN REGIONAL HEALTHCARE SYSTEM
Clinical Nutrition

Patient Name _____

Date of Birth _____

Phone _____

Please fill in or affix patient label

REFERRAL FOR MEDICAL NUTRITION THERAPY (MNT)

Please attach copy of front and back of patient's ***insurance card****, most recent* ***office note, medications*** *and* ***latest labs.***

Patient Address: _____
Street/PO Box City State Zip

Patient Gender: □Male □Female

Please check any potential learning barriers that apply to your patient:

□Impaired vision □Impaired hearing □Impaired speech □Cognitive limitation □Learning disability
□Language barrier □Other:_____

Complete this section only for patients being referred primarily due to <u>diabetes</u>.

Is this the first time this patient has been referred for MNT due to diabetes?

□ Yes, initial referral
□ No, follow-up referral due to:
□ Change in treatment regime □ Change in medical condition/diagnosis
□ Recurrent hyperglycemia □ Recurrent hypoglycemia

Diagnosis w/ICD-10 Code:

□ Type 1 Diabetes without complications- E10.9
□ Type 2 Diabetes without complications- E11.9
□ Gestational Diabetes, diet controlled-024.410
□ Gestational Diabetes, controlled by oral hypoglycemic drugs-024.415
□ Glucose Intolerance-R73.02
□ Type 1 Diabetes with hyperglycemia-E10.65
□ Type 2 Diabetes with hyperglycemia-E11.65
□ Gestational Diabetes, insulin controlled-024.414
□ Gestational Diabetes, unspecified control- 024.419
□ Other _____
Include diagnosis & ICD-10 code

Please check any of the following complicating diagnoses that apply to your patient with diabetes:

□Gastroparesis □Heart Disease □HTN □Hyperlipidemia □Overweight/Obese □Renal Disease
□Other:_____

Appointments for MNT for patients being referred due to diabetes will be scheduled in person at the Paul H. Broyhill Wellness Center or may be done via telephone or telehealth depending upon patient preference and insurance requirements. **Please sign below and fax this form to (828) 386-2049.**

Complete this section for patients who are being referred for MNT primarily due to <u>conditions other than diabetes.</u>

Diagnosis w/ICD-10 Code (check all that apply):

□ Hypoglycemia, unspecified- E16.2
□ Hyperglycemia, unspecified-R73.9
□ Impaired glucose tolerance – R73.02
□ Polycystic ovarian syndrome- E28.2
□ Metabolic syndrome – E88.81
□ Overweight – E66.3
□ Obesity, unspecified- E66.9
□ Morbid obesity- E66.01
□ Hyperlipidemia, unspecified E78.5
□ Hypertension-I10
□ Heart failure, unspecified –I50.9
□ CKD, stage 3-N18.3
□ CKD, stage 4-N18.4
□ CKD, stage 5-N18.5
□ CKD, unspecified-N18.9
□ Other _____
Include diagnosis & ICD-10 code
□Crohn's disease -K50.90
□Other ulcerative colitis- K51.80
□IBS without diarrhea-K58.9
□IBS with diarrhea- K58.0
□Celiac disease-K90.0
□Abnormal weight loss-R63.4
□Protein, calorie malnutrition-E46

Appointments for MNT for patients being referred for conditions other than diabetes will be scheduled in person at Cannon Memorial Hospital or Watauga Medical Center or may be done via telephone or telehealth depending upon patient preference and insurance requirements. **Please sign below and fax this form to Central Scheduling at (828) 268-9046.**

Above patient is referred for medical nutrition therapy as a necessary part of medical treatment for the diagnoses listed.

Physician signature _____**MD/DO** **Date** _____**Time**_____

Print physician name _____

Physician phone_____ **Physician fax**_____