NEBRASKA NUTRITION SERVICES

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REFERRAL FOR OUTPATIENT MEDICAL NUTRITION THERAPY

Patient Name: ______________________ Patient Date of Birth: ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

Patient Insurance: ______________________ Contact Phone Number: ______________

1. Please fax the most recent chart note + labs with referral.

2. Check all [*] diagnoses that may apply for better insurance coverage.

*Diabetes/Endocrine:

- [ ] **E28.2** Polycystic ovarian syndrome
- [ ] **E11.8** Type 2 diabetes with unspecified complications
- [ ] **E11.9** Type 2 diabetes without complications
- [ ] **E11.65** Type 2 diabetes with hyperglycemia
- [ ] **R73.03** Pre-diabetes
- [ ] **R73.01** Impaired fasting glucose
- [ ] **Other** (specify) ______________

*Lipid/Cardiovascular/ Metabolic:

- [ ] **E78.0** Hypercholesterolemia
- [ ] **E78.1** Hypertriglyceridemia
- [ ] **E78.5** Hyperlipidemia, unspec.
- [ ] **I10** Essential hypertension
- [ ] **I12** Hypertensive chronic kidney disease
- [ ] **I25.10** Cardiovascular disease
- [ ] **E88.81** Metabolic syndrome
- [ ] **Other** (specify): ______________

*Abnormal Clinical & Laboratory Findings

- [ ] **R73.03** Pre-diabetes
- [ ] **R73.01** Impaired fasting glucose
- [ ] **Other** (specify) ______________

*Weight Management

- [ ] **R63.4** Abnormal weight loss
- [ ] **R63.5** Abnormal weight gain - not during pregnancy
- [ ] **R63.6** Underweight
- [ ] **R66.8** Other obesity
- [ ] **E66.9** Obesity, unspec.
- [ ] **E66.01** Obesity, morbid (severe) due to excess calories
- [ ] **E66.3** Overweight (BMI 25-29.9)
- [ ] **Other** (specify): ______________

Renal:

- [ ] **N18.1** CKD (stage 1)
- [ ] **N18.2** CKD (stage 2)
- [ ] **N18.31** CKD (stage 3a)
- [ ] **N18.32** CKD (stage 3b)
- [ ] **N18.4** CKD (stage 4)
- [ ] **N18.5** CKD (stage 5)
- [ ] **Z48.22** Encounter for aftercare following kidney transplant
- [ ] **Other** (specify): ______________

Genitourinary:

- [ ] **N20.0** Calculus of kidney

Blood:

- [ ] **D50.9** Iron deficiency anemia, unspecified
- [ ] **Other** (specify): ______________

Gastrointestinal/Liver:

- [ ] **K90.0** Celiac Disease
- [ ] **K57.90** Diverticulosis
- [ ] **K57.92** Diverticulitis
- [ ] **K76.0** Nonalcoholic Fatty Liver
- [ ] **K21.9** Reflux/GERD
- [ ] **K58.9** Irritable Bowel w/o diarrhea
- [ ] **K58.0** Irritable Bowel w/diarrhea
- [ ] **E73.9** Lactose Intolerance
- [ ] **E74.10** Disorder of fructose metabolism, unspecified
- [ ] **Other** (specify): ______________

Other Diagnosis:

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Physician name **(Print)**: ______________________ NPI #: ______________

Physician signature **REQUIRED**: ______________________ Date: ______________

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