MEDICAL NUTRITION THERAPY REFERRAL

Please provide information requested below and **fax** to:
Lynn Clayton, RDN, LDN, CDCES at **844-335-7607**.

Labs (fasting glucose, HgbA1c or OGTT results) required if diabetes

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City/State/Zip: _____

Phone Number(s): _____ (Home/Cell/Work)

Insurance: Yes/No Primary: _____ Secondary: _____

If Yes, include a **copy of insurance card(s).** – If minor, parent's name: _____

Reason for Referral: _____

Check applicable diagnosis code(s): [Please Attach Recent Labs]

Height: _____ Weight: _____

- ☐ E10.65 **Type 1** diabetes mellitus with hyperglycemia
- ☐ E10.69 **Type 1** diabetes mellitus with other specified complication
- ☐ E10.8 **Type 1** diabetes mellitus with unspecified complications
- ☐ E10.9 **Type 1** diabetes mellitus without complications

- ☐ E11.65 **Type 2** diabetes mellitus w/ hyperglycemia
- ☐ E11.69 **Type 2** diabetes mellitus w/ other specified complication
- ☐ E11.8 **Type 2** diabetes mellitus w/ unspecified complications
- ☐ E11.9 **Type 2** diabetes mellitus w/o complications

- ☐ O24.019 Pre-existing diabetes, **type 1, in pregnancy**
- ☐ O24.119 Pre-existing diabetes, **type 2, in pregnancy**
- ☐ O24.410 **Gestational diabetes**, diet controlled
- ☐ O24.414 **Gestational diabetes**, insulin controlled
- ☐ O24.419 **Gestational diabetes**, unspecified control

☐ **Other**: _____

Comments: _____

- ☐ R73.01 Impaired fasting glucose
- ☐ R73.02 Impaired glucose tolerance
- ☐ R73.03 Pre-Diabetes
- ☐ E28.2 PCOS

- ☐ E78.0 Pure hypercholesterolemia
- ☐ E78.1 Pure hyperglyceridemia
- ☐ E78.2 Mixed hyperlipidemia
- ☐ E78.4 Other hyperlipidemia
- ☐ E78.5 Hyperlipidemia, unspecified

- ☐ E66.3 Overweight
- ☐ E66.9 Obesity, unspecified
- ☐ E66.01 Morbid (severe) obesity

- ☐ K31.84 Gastroparesis
- ☐ K90.0 Celiac Disease
- ☐ N18.9 Chronic Kidney Disease
  Stage of CKD _____
- ☐ Z91.0 Food Allergy (specify)

_____

Referring Provider Name: _____ (please print)

Office Phone #: _____ Office Fax #: _____

Name of Referral Coordinator: _____

Provider Signature: _____ **Date**: _____

Clayton Nutrition & Diabetes Services
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