



REFERRAL



This form may be completed on line. Tab or move cursor to text field and type in text.

Physician Referral
Outpatient
MEDICAL NUTRITION THERAPY (MNT)

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Form Origination Date: 6/04
Version: 3

Version Date: 5/06

For HIPAA Compliance reasons, this form IS NOT TO BE SAVED with patient information. Selecting the PRINT button will clear all information from the note.

Patient Name _____
MRN _____

STAMP PLATE AREA

Patient Phone #: _____ SS#: _____
Medicare #: _____
DOB: _____ Age: _____

Scheduling Appointments:

Adult Services: Phone: 843-876-0888 Fax: 843-792-2995
Transplant Services: Phone: 843-792-6100 Fax: 843-792-6110
Pediatric Services: Phone: 843-876-0444 Fax: 843-876-0442

Diagnosis: (must be checked (✓)):

- Diabetes without complications 250.0 _____
- Diabetes with ketoacidosis 250.1 _____
- Diabetes with hyperosmolarity 250.2 _____
- Diabetes with renal manifestations 250.4 _____
- Diabetes with ophthalmic manifestations 250.5 _____
- Diabetes with neurological manifestations 250.6 _____
- Diabetes with peripheral circulatory disorders 250.7 _____
- Diabetes with other specified manifestations 250.8 _____
- Diabetes with unspecified complication 250.9 _____
- Gestational Diabetes 248.8 _____
- Moderate kidney failure 585.3
- Severe kidney failure 585.4
- Kidney failure 585.8
- End stage 585.6
- Unspecified 585.9
- Status post renal transplant V42.0
- Other Diagnosis: _____

Check the 5th number for Diabetes Mellitus

- | | | |
|---|-----|---|
| 0 | ___ | Type 2 diabetes or unspecified type, controlled |
| 1 | ___ | Type 1 diabetes, controlled |
| 2 | ___ | Type 2 diabetes or unspecified type, uncontrolled |
| 3 | ___ | Type 1 diabetes, uncontrolled |

Medical Nutrition Therapy Order: (must check (✓) one)

Diabetes: Type 1 Type 2 Gestational Diabetes
Renal: Renal failure, Non Dialysis Status Post Renal Transplant
Comments: _____

PERTINENT LABS (Must be provided for Diabetes and Renal Disease):

_____ Fasting Blood Glucose (> 126 mg/dL), Random BG >200, or 2 hour GTT ≥ 200
_____ Glomerular Filtration Rate (13-50 mL/min/1.73m²) OR _____ mg/dL Serum Creatinine

Print Physician Name: _____ UPIN: _____

Physician Signature: _____ Date: _____

Physician Phone #: _____ Pager ID: _____ Fax: _____

*Place original in patient's medical record.
MNTREFER