Referral for Medical Nutrition Therapy (MNT) at CICOA Aging & In-Home Solutions

~ Medicare covers MNT for Dx: CKD, DM1, DM2, kidney transplant ~

Date:	**Patient Name:**
Patient Phone Number:	**Medicare Number:**
Patient Email Address:	
Patient DOB:	**Home Address:**

PLEASE ATTACH or FAX (317)-803-6160 A COPY OF THE FRONT & BACK OF THE PATIENT'S MEDICARE CARD AND DRIVERS LICENSE, ANY RELEVANT LAB WORK, AND MEDICAL RECORDS.

Above is being referred for Medical Nutrition Therapy as a necessary part of medical treatment and prevention of complications for diagnoses listed.

Reason for Referral (circle): New Diagnosis New Treatment Plan New Complication

Other: _____

Special Needs (circle): Language Hearing/Speech/Vision Learning/Processing

Other:_____

Check all diagnoses that apply to this referral. List any others in the blank spaces.

√	IDC-10	IDC-10 Description	√	IDC-10	IDC-10 Description
	E10	T1DM			
	E11	T2DM			
	N18.9	CKD, unspecified			
	N18.1	CKD stage 1			
	N18.2	CKD stage 2			
	N18.3	CKD stage 3			
	N18.31	CKD stage 3a			
	N18.32	CKD stage 3b			
	N18.30	CKD stage 3 unspecified			
	N18.4	CKD stage 4			
	N18.5	CKD stage 5			
	Z48.22	Encounter for aftercare following kidney transplant			
	Z94.0	Kidney transplant status			
		Other			

Lab Work: (please attach, fax (317)-803-6160, or complete below)

BP	FBS	Glucose	Total Chol	HDL	Trig	LDL	A1c	Total protein	Albumin	PTH	CRP	Vit D	B12
___/___													
	Hgb	Hct	Plat	Na	K+	Cl	Phos	BUN	Creat	eFGR	ALT	AST	Alk Phos

Current Diet Order: _____

Medications: (please attach) _____

Physician signature X_____ **MD Phone #** _____

Print name X_____

NPI #: _____ **Fax #**: _____