Kidney Foodie

Kidney Foodie, LLC
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Medical Nutrition Therapy (MNT) Referral Form

Patients: Please scan here to request your appointment

Patient's Name_____

Patient DOB:_____

Patient Phone : _____

Patient email :_____

Relevant Diagnosis Code/S (Required). **Please check all that apply:**

	Q61.__	Cystic Kidney Disease_____
	N18.1	**CKD, Stage I***
	N18.2	**CKD Stage II***
	N18.31	**CKD Stage IIIa***
	N18.32	**CKD Stage IIIb***
	N18.4	**CKD, Stage IV***
	N18.5	**CKD, Stage V***
	E__.___	**Diabetes :_____***
	I10	Essential (primary) hypertension
	E78.00	Pure hypercholesterolemia, unspecified
	E78.1	Pure hyperglyceridemia
	E78.2	Mixed hyperlipidemia
	E78.4	Other hyperlipidemia
	N20.___	Calculus :
	N21.___	Calculus :
	R63.4	Abnormal weight loss
	R63.5	Abnormal weight gain
	R63.6	Underweight
	E66.3	Overweight
	E66.8	Other Obesity
	E66.9	Obesity, unspecified

Other DX and ICD-10 Code/s (specify):

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***For Medicare Beneficiaries, one of these diagnosis codes is required to cover services.**

Print Physician Name:_____

Physician Phone/Fax: _____

Physician NPI: _____

Physician Signature: _____ Date: _____

Please fax completed form most recent visit summary, and any relevant labs to 404-868-8136