Diabetes Medical Nutrition Therapy (MNT) Referral Form to:

Kirsten A. Angell, RD, LD, CDE
PO Box 65
Gove, KS 67736

Phone: 785-410-3599
Fax form to: 785-938-2322
kirsten@link4nutrition.com

Patient's Last Name: Patient's First Name: Patient's Middle Initial:

Address: City: State/Zip Code:

Preferred Contact #: Other Contact #(s): E-mail Address:

Gender: M/F DOB: Insurance:

Ht: Wt.: Waist Circumference: Physical Activity Restrictions: No Yes

Lab	Value	Date
BP	mmHg	
Glucose	mg.dL	
A1C	%	
TC	mg.dL	
HDL	mg.dL	
LDL	mg.dL	
TG	g/dL	
Cr	mg/dL	
GFR	mL/min	
Microalbumin	mg	

Med	Dose	Frequency
(attach extra page, if necessary)		

ICD-10 Medical DX (circle all that apply)

E11.9	Type 2 DM w/o complications	024.01	Pre-ex. DM, type 1, in preg.
E10.9	Type 1 DM w/o complications	024.11	Pre-ex. DM, type 2, in preg.
E11.65	Type 2 DM w/ hyperglycemia	021.41	GDM, diet-controlled
E10.65	Type 1 DM w/ hyperglycemia	024.414	GDM, insulin-controlled
E11.69	Type 2 DM w/ other spec. comp.	R73.01	Impaired fasting glucose
E10.10	Type 1 DM w/ ketoacidosis	R73.02	IGTT (oral)
Other (please list with ICD-10):		E16.2	Hypoglycemia, unspecified

Reason for MNT (circle all that apply):

Nutrition — Medication Ed.
Physical Activity — Disease Process
Monitoring — Complication Ed.
Goal Setting/Problem Solving — Psychological Adjustment

Complications/Comorbidities (circle all that apply):

HTN — Neuropathy — PVD — Obesity
Dyslipidemia — Retinopathy — CAD — Kidney Disease
Other (please list): ____________________

MNT Frequency:

Initial MNT/new dx (3 hrs. in calendar yr. of dx)
Annual follow-up MNT (2 hrs. annually)
Additional hrs. requested: ____________
List reason (change in medical cond., tx, &/or dx):
____
____
____

Physician's Signature: **NPI #:**

Practice Contact Information: **Date:**