TKS Nutrition, LLC
Healthy Habits for Life

Physician Referral for Medical Nutrition Therapy

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Patient Information:

Patient Name: _____ DOB: _____
Home #: _____ Cell #: _____ Email: _____
Address: _____
Insurance Name: _____ Plan/Group #: _____

Physician Order: Registered Dietitian to assess and provide Medical Nutrition Therapy (MNT)

- ✓ Initial MNT (CPT code 97802)
- ✓ Follow-Up MNT (CPT code 97803)
- ☐ Additional MNT services in the same calendar year (Please specify change in diagnosis, medical condition or treatment regimen): _____

Diagnosis: Check diagnosis or add other diagnosed disease/ condition code

Please send with referral: office notes, weight history, medication list and lab work

☐ Abnormal weight gain R63.5	☐ Diabetes, Type 2 SPECIFY TYPE E11._____	☐ Hypertension, essential I10
☐ Abnormal weight loss R63.4	☐ Diabetes, Gestational SPECIFY TYPE O24._____	☐ Hypoglycemia, unspecified E16.2
☐ Anemia D64.9	☐ Diabetes, Type 1 w/ pregnancy SPECIFY TYPE O24._____	☐ Hypothyroidism, unspecified E03.9
☐ Anemia, Iron Deficiency D50.9	☐ Diabetes, Type 2 w/ pregnancy SPECIFY TYPE O24._____	☐ Irritable Bowel Syndrome w/ diarrhea K58.0
☐ Anorexia R63.0	☐ Diabetes, Pre R73.03	☐ Irritable Bowel Syndrome w/o diarrhea K58.9
☐ Anorexia Nervosa F50.00	☐ Diarrhea K59.1	☐ Malnutrition- Protein/calorie, moderate E44.0
☐ Bulimia F50.2	☐ Diverticulosis: specify type: K57. _____	☐ Malnutrition- protein/calorie mild E44.1
☐ Celiac Disease K90.0	☐ Diverticulitis: specify type: K57._____	☐ Malnutrition – protein/calorie unspecified E46
☐ CKD Stage 1 N18.1	☐ Eating Disorder, unspecified F50.9	☐ Metabolic Syndrome E88.81
☐ CKD Stage 2 N18.2	☐ Failure to Thrive, Child R62.51	☐ Morbid Obesity E66.01
☐ CKD Stage 3 N18.3	☐ Failure to Thrive, Adult R62.7	☐ Obesity E66.09
☐ CKD Stage 4 N18.4	☐ Food Allergy K52.2	☐ Overweight E66.3
☐ CKD Stage 5 N18.5	☐ GERD, esophagitis K21.0	☐ Polycystic Ovary Syndrome E28.2
☐ Constipation, unspecified K59.00	☐ Hypercholesterolemia E78.0	☐ Underweight R63.6
☐ Crohn's Disease: Specify type K50.____	☐ Hypertriglyceridemia E78.1	☐ Vitamin D Deficiency E55.9
☐ Diabetes, Type 1 SPECIFY TYPE E10._____	☐ Hyperlipidemia, mixed E78.2	☐ Other: _____

MEDICARE MEDICAL NUTRITION THERAPY ELIGIBILITY CRITERIA:

Must provide ONE of these diabetes diagnostic criteria (date and value)

- FBG lab ≥126 mg/dl on 2 tests: FBG:_____ and FBG:_____
- 2 hr OGTT lab ≥200 mg/dl on 2 tests: 2 hr OGTT:_____ and 2 hr OGTT:_____
- Random BG lab ≥200 mg/dl with symptoms of uncontrolled diabetes: Random BG:_____
  ☐ excessive thirst ☐ excessive urination ☐ excessive hunger ☐ blurry vision ☐ excessive tiredness ☐ unintentional wt loss
  ☐ tingling in extremities ☐ other:_____

For MEDICARE Renal MNT (date and value)

- GFR lab:_____ (note: 13 to 50 required for Medicare eligibility)

I hereby certify that I am treating this patient for the above diagnosis and that the prescribed medical nutrition therapy is a necessary part of the patient's medical treatment.

Physician Signature: _____ **Date:** _____
Printed Physician Name: _____ **NPI #:** _____
Office Phone #: _____ **Fax #:** _____