MedNetOne HEALTH SOLUTIONS

REFERRAL FORM

Medical Nutrition Therapy
Diabetes Self Management Education

Phone number: 248-475-4701 Fax number: 248-475-5777

PATIENT INFORMATION

Date:	Patient's Name:	DOB:	Age:
Phone # (H):	Phone # (W):	Phone# (C):	
Address:		Email:	
Health Insurance:	Contract ID Number:		

NEED FOR SELF-MANAGEMENT EDUCATION

☐ **Medical Nutrition Therapy**: Please describe reason for patient referral:_____

Medicare: 3 hours initial MNT in the first calendar year, plus two hours follow-up MNT annually. Additional MNT hours are available for change in medical condition, treatment and/or diagnosis. Please check the type of MNT and/or number of additional hours requested.

☐ Initial MNT ☐Annual follow-up MNT

☐ Additional Services in the same calendar year, per RD recommendation _____ hours requested

Blood Pressure: _____/_____ Height: _____ Weight: _____

☐**Diabetes Self Management Training (9-11 hours)** is medically necessary for the following reasons**:**

☐ Recent Diagnosis (please include diagnostic lab work) ☐ Poorly controlled diabetes ☐ Lack of current self-care knowledge/skills

Diagnosis: (Check all that apply)

☐	Diabetes Type 1	E10	☐	Morbid Obesity	E66.01
☐	Diabetes Type 2	E11	☐	Obesity	E66.9
☐	Heart Disease	I51.9	☐	Pre-diabetes	R73.09
☐	Hyperlipidemia	E78.5	☐	Post-surgical malabsorption	K91.2
☐	Hypertension	I10	☐	Renal Disease	N28.9
☐	Hypoglycemia	E16.2	☐	Other: _____	

****Please attach lab work:**

- FBS
- RBS
- HgbA1C
- Cholesterol
- HDL
- LDL
- Triglycerides
- Micro albumin
- Other: _____

List Medications:

Medication	Dosage	Frequency

REFERRING PHYSICIAN INFORMATION

Physician/Clinician Signature:	Phone:
Physician/Clinician Name (Print):	Fax:
Physician Address:	NPI Number:

*****Please provide patient with a copy and fax a copy to (248) 475-5777**

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