

Please return this form to Linda Arpino's confidential FAX line (866)293-4500

Offices: 558 Westchester Avenue Rye Brook
21 Craig Court, Stamford, CT
(NEAR Pound Ridge NY and New Canaan CT)

Main Telephone # (914) 935-0123
or (203)321-8454

Instructions for completing the Physician Referral Form

This form does not supersede insurance referrals, or is a replacement for insurance referrals needed. We need this to treat the patient accurately. Please provide this page and the Physicians Referral Form to your physician.

Patients:

Complete on the form, the following information:

- Patients name
- Date of birth
- Contact information

Primary Care Physician must complete this information especially if an insurance claim is submitted:

- Diagnosis **and** diagnosis code (ICD-9 code)
- Pertain Laboratory Findings
- Clearance to Exercise
- Physician's name, signature, contact information and NPI #

Common ICD-9 codes that qualify for reimbursed MNT

Diabetes mellitus = 250.0

- If type 2 add **.00**
- If type 1 add **.01**
- If type 2 uncontrolled add **.02**
- If type 1 uncontrolled add **.03**

Hypertension= 402.00

Hyperlipidemia= 272.00

Hyper/ hypo thyroid

Obesity =278.00 overweight

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Please attach current list of medications, dosages & current lab results and return.

Date:	Patient name:	Gender:	Date of Birth:
Day time phone number:	Insurance:	Physicians Name:	
Height:	Weight:	MD Telephone #	
I acknowledge and authorize release or information to health care provider/s listed and give permission to share my healthcare treatment plan including medication and pertinent lab tests.			
Patient/Guardian _____		Date: _____ If Guardian, Print name here:	

MEDICAL DIAGNOSES (check all that apply below)		Required in order to initiate MNT service	
ICD-9	ENDOCRINE, NUTRITIONAL AND METABOLIC, IMMUNITY	ICD-9	EATING DISORDERS
250.00	Diabetes II/unspecified	307.783.6	Anorexia Bulimia
250.01	Diabetes I		DIGESTIVE SYSTEM
250.02	Diabetes II/unspecified, uncontrolled	555.9	Crohn's disease NOS
250.03	Diabetes I, uncontrolled	556.0	Ulcerative (chronic) enterocolitis
250.1	Diabetes with ketoacidosis	562.10	Diverticulosis of colon
251.2	Hypoglycemia, unspecified	562.11	Diverticulitis of colon
256.4	Polycystic ovarian syndrome	564.1	Irritable bowel syndrome
271.3	Intestinal disaccharidase deficiencies and disaccharide malabsorption	575.9	Unspecified disorder of gallbladder
271.9	Unspecified disorder of carbohydrate transport and metabolism		GENITOURINARY SYSTEM
272.0	Pure hypercholesterolemia	585.3	Chronic kidney disease, Stage III (moderate)
272.1	Pure hyperglyceridemia	585.4	Chronic kidney disease, Stage IV (severe)
272.4	Combined hyperlipidemia	585.5	Chronic kidney disease, Stage V
272.2	Mixed hyperlipidemia	585.9	Chronic kidney disease, unspecified
272.9	Unspecified disorder of lipid metabolism		SKIN AND SUBCUTANEOUS TISSUE
277.7	Dysmetabolic syndrome X	693.1	Dermatitis: Due to food
278.00	Obesity, unspecified		Other _____
278.01	Morbid obesity		SYMPTOMS, SIGNS, ILL-DEFINED
278.02	Overweight	783.21	Loss of weight
	CIRCULATORY SYSTEM	790.2	Abnormal glucose
401.0-401.9	Essential hypertension	733.90	Osteopenia
402.0-402.9	Hypertensive heart disease	733	Osteoporosis

Relevant Medications and Dosages (type/frequency): _____ Relevant Lab Data: _____
(attach current lab data)

Physical Activity Restrictions: none: _____ limit to: _____

Comments (medical conditions, goals for nutrition therapy): _____

MD Signature: _____ Date: _____

Print or Stamp MD Name: _____

Address: _____ ZIP _____