



**REFERRAL FORM MARY JOHANN ARNP, FNP-BC, BC-ADM
COMPREHENSIVE DIABETES MEDICATION AND DEVICE MANAGEMENT**

SALUTE NUTRITION, PLLC - Phone: 425-285-5877 - Fax: 425-977-0227 Multiple Locations – Telehealth
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Instructions: Please fax (or scan and email) this completed form along with demographic sheet and pertinent labs and medication list. Please call with questions or to coordinate care.

Name: _____ Date of Birth: ____/____/____
 Primary phone number: _____ Secondary phone number: _____
 Email: _____ Insurance: _____
 Address _____ City _____ Zip _____

Commonly used ICD-10 Codes. Please check all that apply and alter/change as needed.

<ul style="list-style-type: none"> <input type="checkbox"/> Z68.____ : Body mass index (BMI): _____, adult <input type="checkbox"/> E66.0 : Obese due to excess calories <input type="checkbox"/> E66.01 : Morbid (severe) obesity due to excess calories <input type="checkbox"/> E66.3 : Overweight <input type="checkbox"/> E66.8 : Other obesity <input type="checkbox"/> E66.9 : Obesity, unspecified – obesity NOS <input type="checkbox"/> R63.4 : Abnormal weight loss <input type="checkbox"/> R63.5 : Abnormal weight gain – not during pregnancy <input type="checkbox"/> R63.6 : Underweight I10 : Essential (primary) hypertension <input type="checkbox"/> E78.0 : Pure hypercholesterolemia <input type="checkbox"/> E78.1 : Pure hyperglyceridemia <input type="checkbox"/> E78.2 : Mixed hyperlipidemia <input type="checkbox"/> E78.5 : Hyperlipidemia, unspecified <input type="checkbox"/> E88.81 : Metabolic syndrome <input type="checkbox"/> F50.____ : Anorexia nervosa, _____ <input type="checkbox"/> F50.2 : Bulimia nervosa <input type="checkbox"/> F50.9 : Eating disorder, unspecified <input type="checkbox"/> D50.8 : Other iron deficiency anemias (due to inadequate iron intake) 	<ul style="list-style-type: none"> <input type="checkbox"/> E10.____ : Type 1 diabetes mellitus, _____ <input type="checkbox"/> E11.____ : Type 2 diabetes mellitus, _____ <input type="checkbox"/> E16.1 : Other hypoglycemia <input type="checkbox"/> E28.2 : Polycystic ovarian syndrome <input type="checkbox"/> E03.9 : Hypothyroidism, unspecified <input type="checkbox"/> R73.01 : Impaired fasting glucose <input type="checkbox"/> R73.02 : Impaired glucose tolerance test <input type="checkbox"/> R73.03 : Pre-diabetes <input type="checkbox"/> K21.____ : Gastroesophageal reflux disease, _____ <input type="checkbox"/> K50.____ : Crohn’s disease, _____ <input type="checkbox"/> K51 : Ulcerative colitis <input type="checkbox"/> K58 : Irritable bowel syndrome <input type="checkbox"/> K59 : Constipation <input type="checkbox"/> K90.0 : Celiac disease <input type="checkbox"/> O21.0 : Mild hyperemesis gravidarum <input type="checkbox"/> O24.____ : Pre-existing diabetes mellitus, type _____, in pregnancy <input type="checkbox"/> O24.410 : Gestational diabetes mellitus, diet-controlled <input type="checkbox"/> OTHER _____ <input type="checkbox"/> Z71.3 : Dietary counseling and surveillance
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PLEASE INCLUDE MEDICAL NUTRITION THERAPY AND/OR DSME PROVIDED BY REGISTERED DIETITIAN

Date: ____/____/____ Physician name (printed): _____

Physician signature _____ NPI: _____

Group/Practice Name: _____ Office Phone: _____ Office Fax: _____