REFERRAL FORM

MARY JOHANN ARNP, FNP-BC, BC-ADM
ADVANCED DIABETES MANAGEMENT CLINICIAN

COMPREHENSIVE DIABETES MEDICATION, INSULIN AND DEVICE MANAGMENT

SALUTE NUTRITION, PLLC - Phone: 425-285-5877 (office manager message phone) - Fax: 425-977-0227
Location: 7614 195th St SW Edmonds, WA 98026
Email: admin@salutenutritionpllc.com **Website:** www.salutenutritionpllc.com

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.

- ❑ Z68.___ : Body mass index (BMI):________, adult
- ❑ E66.0 : Obese due to excess calories
- ❑ E66.01 : Morbid (severe) obesity due to excess calories
- ❑ E66.3 : Overweight
- ❑ E66.8 : Other obesity
- ❑ E66.9 : Obesity, unspecified – obesity NOS
- ❑ I10 : Essential (primary) hypertension
- ❑ E78.0 : Pure hypercholesterolemia
- ❑ E78.1 : Pure hyperglyceridemia
- ❑ E78.2 : Mixed hyperlipidemia
- ❑ E78.5 : Hyperlipidemia, unspecified
- ❑ E88.81 : Metabolic syndrome
- ❑ E10.___: Type 1 diabetes mellitus, ______
- ❑ E11.___: Type 2 diabetes mellitus, ________
- ❑ E16.1 : Other hypoglycemia
- ❑ E28.2 : Polycystic ovarian syndrome
- ❑ E03.9 : Hypothyroidism, unspecified
- ❑ R73.01 : Impaired fasting glucose
- ❑ R73.02 : Impaired glucose tolerance test
- ❑ R73.03 : Pre-diabetes
- ❑ O24.___ : Pre-existing diabetes mellitus, type _____, in pregnancy
- ❑ O24.410 : Gestational diabetes mellitus, diet-controlled
- ❑ Insulin pump assessment
- ❑ OTHER ____

- ❑ **PATIENT IS ON CONTINUOUS GLUCOSE MONITOR (BRAND): ____________**
- ❑ **PATIENT IS ON INSULIN PUMP (BRAND): _______________**
- ❑ **PLEASE INCLUDE MEDICAL NUTRITION THERAPY AND/OR DSME SERVICES PROVIDED BY REGISTERED DIETITIAN/CERTIFIED DIABETES CARE AND EDUCATION SPECIALIST (CDCES)**

Date: ___/____/____Physician name (printed):____

Physician signature____NPI:______________

Group/Practice Name: ___________________Office Phone:__________Office Fax:____________________