## PLEASE SEND THE FOLLOWING:

1. Diet Prescription:
    a. Provide diagnoses
    b. Select diet prescription—either RD determines or you specify diet.
    c. Sign and date
2. H & P related to the referral diagnoses.
3. Latest labs
4. Patient demographics with insurance information.

## FAX to: (949)329-1279

If you have questions or concerns, feel free to contact me at:

Phone (949)259-0787

Email: Saghar@AvicennaDietetics.com

***Insurances: We accept Medicare (For diabetes or CKD), United, Healthnet and Blue Cross)***

Thank you for your referral,

Avicenna Dietetics

Patient's Name________________________ Date of Birth_____________________ Date_________________________

## **Medical Nutrition Therapy for:** (Check (x) boxes that apply)

☐ **DIABETES** Insulin Use – Z79.4 _____

☐ **Type 1-E10.**_____
- ☐ with ketoacidosis,w/o coma—E10.10
- ☐ with CKD—E10.22
- ☐ with neurological unspec—E10.40
- ☐ with circulatory complications—E10.59
- ☐ with hypoglycemia w/o coma—E10.649
- ☐ with hyperglycemia—E10.65
- ☐ without complications—E10.9

☐ **Type 2-E11.**_____
- ☐ with CKD—E11.22
- ☐ with neurological complications—E11.49
- ☐ with circulatory complications—E11.59
- ☐ with hypoglycemia, unspec—E16.2
- ☐ with hyperglycemia—E11.65
- ☐ without complications—E11.9
- ☐ with kidney complications—E11.29

☐ **Pre-Diabetes**—R73.09

☐ **Gestational-024.41** **+wks gest-Z3A** _____
- ☐ Pre-existing DM,Type 1 in PG, unspec trim—024.019
- ☐ Pre-existing Type 2 in PG, unspec trim—024.119
- ☐ GDM in Preg, unspec controlled—024.419

☐ **CARDIAC**
- ☐ Hyperlipidemia, unspec—E78.5
- ☐ Hypercholesterolemia, unspec—E78.00
- ☐ Hypertension, essential, —I 10
- ☐ Hypertension, unspecified, CKD 1-4 —I 12.

☐ **CHRONIC KIDNEY DISEASE**
- ☐ **Renal failure chronic**
  - ☐ Stage 3—N18.3
  - ☐ Stage 4—N18.4
  - ☐ Stage 5—N18.5
- ☐ **Renal Transplant**—Z94.0 **+Hypertension or unspecified CRF**—I 12.9

☐ **GI**
- ☐ Celiac Disease, w/o compl—K90.0
- ☐ Crohn's disease of small intest w/o compl—K50.00
- ☐ Crohn's disease large intest w/o compl—K50.10
- ☐ Crohn's disease small & large intest w/o compl—K50.80
- ☐ Ulcerative colitis, unspec—K51.9
- ☐ Irritable Bowel Syndrome, unspec—K58.8
- ☐ S/P malabsorption—K91.2

☐ **WEIGHT MANAGEMENT**
- ☐ Obesity, morbid related to excess calories—E66.01
- ☐ Obesity, related to excess calories—E66.09
- ☐ Overweight—E66.3
- ☐ Underweight—R63.6

☐ **OTHER** _____

☐ **PREVENTIVE DIETARY COUNSELING AND SURVEILLANCE—Z71.3**

☐ **EATING DISORDERS**
- ☐ Anorexia Nervosa, unspecified—F50.00
- ☐ Anorexia nervosa, restricting type—F50.01
- ☐ Anorexia nervosa, binge eating/purging type—F50.02
- ☐ Bulimia nervosa—F50.2
- ☐ Eating disorder, unspecified—F50.9

**Select One:**

☐ Registered Dietitian will determine diet prescription based on MNT protocols. Visits will consist of an initial and two follow-ups and/or based on client need.

☐ Specific Diet: ________________________ ☐ Weekly ☐ 2x/month ☐ Monthly

Physician's Signature ______________________________________________ Date: ____________

Physician's Name: ______________________________________________________

Telephone Number: ______________________________ Fax Number: ______________________

Physician's NPI: ______________________________________________

**Avicenna Dietetics** **26730 Towne Centre Dr STE 102, Foothill Ranch Ca, 92610** **Phone (949)259-0787. Fax (949)329-1279**
**1735 W Romneya Dr, Anaheim, CA 92801**

Patient's Name________________________ Date of Birth_____________________ Date_________________________

# Physical Activity Clearance Form

Please answer the questions regarding the referred patient:

1. Can patient engage in normal physical activities?  Y  N
2. Is patient clear for exercise?  Y  N

Physician's Signiture ___________________________________________________________

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