

CKD Diet Counseling (Medical Nutrition Therapy) Referral Form

NAME _____ DATE OF BIRTH _____ MEDICAL RECORD # (IF APPLICABLE) _____
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REASON FOR REFERRAL *Medical nutrition therapy for chronic kidney disease. Specific concerns or questions:*

CKD DIAGNOSTIC CODE N OTHER DIAGNOSTIC CODE(S)

BLOOD PRESSURE WEIGHT HEIGHT
 RECENT WEIGHT CHANGE? YES NO AMOUNT GAIN LOSS

FOR DIABETICS YEAR OF DIAGNOSIS A1C MONTH/YEAR |

LABORATORY ASSESSMENT *(most recent values)*

ALBUMINURIA NOT PRESENT IF PRESENT, SINCE MONTH/YEAR |
 UACR *(Urine Albumin-to-Creatinine Ratio)* MONTH/YEAR |

CREATININE eGFR *(Estimated Glomerular Filtration Rate)* MONTH/YEAR |
calculate eGFR

K HCO3 BUN Ca Phos Hgb
 LDL HDL TG iPTH Vit D Alb

CURRENT MEDICATIONS *(or attach list)*

KNOWLEDGE DOES THE PATIENT KNOW HE/SHE HAS KIDNEY DISEASE? YES NO DON'T KNOW
 DOES THE PATIENT KNOW THE SEVERITY? YES NO DON'T KNOW
 IS THE PATIENT AWARE THAT HE/SHE MAY NEED DIALYSIS? YES NO DON'T KNOW
 PREVIOUS DIET COUNSELING FOR CKD? YES NO DON'T KNOW

ADDITIONAL INFORMATION

ORDER: Initial MNT and follow-up
 Extension with medical justification
 Diagnosis change
 Change in medical condition
 Annual renewal

REFERRED BY _____ NPI # _____

SIGNATURE _____ DATE _____

PHONE _____ FAX _____ EMAIL _____

Rationale for Data Inclusion

The following information explains why it is important to include data for various sections of the CKD Diet Counseling Referral Form (www.nkdep.nih.gov/resources/ckd-diet-referral-form-508.pdf)

BLOOD PRESSURE	Uncontrolled blood pressure is associated with more rapid progression. Control of hypertension is also a key opportunity to slow the rate of progression of chronic kidney disease (CKD).
RECENT WEIGHT CHANGE	Trend in weight status is critical for assessing inadequate intake (loss) or fluid retention (gain).
FOR DIABETICS	Presence or absence of diabetes is critical to establishing an etiology for kidney disease and risk for progression. Duration of diabetes is useful for determining the likelihood that the patient's CKD is caused by diabetes.
ALBUMINURIA	The presence and quantity of albuminuria may be used to assess kidney damage. High levels of albuminuria are associated with more rapid progression of CKD and loss of renal function.
URINE ALBUMIN-TO-CREATININE RATIO (UACR)	Persistently elevated levels of urine albumin are used to identify and quantify kidney damage. High UACR levels are associated with more rapid progression to kidney failure. Generally reported as milligrams albumin/ grams creatinine, monitoring trends in UACR may be useful when educating patients about self-management efforts and prognosis.
ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)	eGFR is used to assess kidney function. The rate of eGFR decline varies by etiology and among individuals with the same etiology. A decrease in the rate of decline of eGFR may reflect response to therapy. Monitoring trends in eGFR may be useful when educating patients about self-management efforts and prognosis.
SERUM POTASSIUM (K)	Presence or absence of hyperkalemia is useful when determining potassium prescription. Potassium restriction is not indicated in the absence of hyperkalemia.
SERUM BICARBONATE (HCO₃)	A low level, defined as < 22 milliequivalents per liter, may indicate metabolic acidosis in CKD and may reflect reduced acid excretion and reduced base production by the kidneys.
BLOOD UREA NITROGEN (BUN)	Increasing blood urea nitrogen levels may indicate reduced clearance of nitrogenous waste.
SERUM CALCIUM (Ca)	Calcium levels are used to assess and monitor abnormal mineral metabolism and bone disorders in CKD. Vitamin D supplements may be prescribed for hypocalcemia. Use of vitamin D may increase the risk for hypercalcemia.
SERUM PHOSPHORUS (Phos)	Phosphorus levels are used to assess and monitor abnormal mineral metabolism and bone disorders in CKD. Use of vitamin D may increase the risk for hyperphosphatemia.
HEMOGLOBIN (Hgb)	Patients with CKD are at risk for anemia due to reduced levels of erythropoietin, a hormone produced by the kidneys. Iron studies may be indicated prior to iron supplementation or use of erythropoiesis-stimulating agents.
LOW DENSITY LIPOPROTEIN (LDL)	LDL levels are used to assess and monitor dyslipidemia in CKD.
HIGH DENSITY LIPOPROTEIN (HDL)	HDL levels are used to assess and monitor dyslipidemia in CKD.
TRIGLYCERIDES (TG)	Triglyceride levels are used to assess and monitor dyslipidemia in CKD.
INTACT PARATHYROID HORMONE (iPTH)	iPTH is used to assess and monitor abnormal mineral metabolism and bone disorders in CKD. Levels may be reduced with vitamin D supplementation.
VITAMIN D (25-hydroxy vitamin D)	Patients with CKD are at risk for hypovitaminosis D due to reduced levels of 25-OH Vit D as well as decreased 1-OH activation in the kidneys.
SERUM ALBUMIN (Alb)	Albumin may be useful to assess and monitor nutritional status in CKD. Hypoalbuminemia is associated with inflammation and poor prognosis in CKD.
CURRENT MEDICATIONS	Medication lists are crucial to assess for medication-nutrient interactions and patient self-management education.