

CKD Diet Counseling (Medical Nutrition Therapy) Referral Form

NAME Carlos Mendes **DATE OF BIRTH** 02 | 07 | 1945 **MEDICAL RECORD # (IF APPLICABLE)** 122222

REASON FOR REFERRAL *Medical nutrition therapy for chronic kidney disease. Specific concerns or questions:*

Approaching kidney failure, experiencing hypoglycemia. Provide nutrition recommendations to maintain status.

CKD DIAGNOSTIC CODE 585.4 **OTHER DIAGNOSTIC CODE(S)** 240.42

BLOOD PRESSURE 139/82 **WEIGHT** 203 # **HEIGHT** 70 "
RECENT WEIGHT CHANGE? YES NO **AMOUNT** GAIN LOSS

FOR DIABETICS **YEAR OF DIAGNOSIS** 1999 **A1C** 6.6 **MONTH/YEAR** 3 | 2012

LABORATORY ASSESSMENT *(most recent values)*

ALBUMINURIA NOT PRESENT IF PRESENT, SINCE **MONTH/YEAR** 2005

UACR *(Urine Albumin-to-Creatinine Ratio)* 484, was 671 **MONTH/YEAR** 3 | 2012

CREATININE 3.1 **eGFR** *(Estimated Glomerular Filtration Rate)* 20 **MONTH/YEAR** 3 | 2012

calculate eGFR

K 5.3 **HCO₃** 20.2 **BUN** 43 **Ca** 8.4 **Phos** 4.3 **Hgb** 12.4
LDL 104 **HDL** 38 **TG** 136 (9/11) **iPTH** 45 **Vit D** 23 **Alb** 2.5

CURRENT MEDICATIONS *(or attach list)*

Enalapril 10 milligrams (mg) daily, lovastatin 40 mg daily, baby aspirin daily, renal vitamin, ergocalciferol 50,000 I.U. weekly.
Changes: ADD furosemide 80 mg daily, DISCONTINUE Glipizide XL 10 mg.

KNOWLEDGE

DOES THE PATIENT KNOW HE/SHE HAS KIDNEY DISEASE?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> DON'T KNOW
DOES THE PATIENT KNOW THE SEVERITY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input checked="" type="checkbox"/> DON'T KNOW
IS THE PATIENT AWARE THAT HE/SHE MAY NEED DIALYSIS?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> DON'T KNOW
PREVIOUS DIET COUNSELING FOR CKD?	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	<input type="checkbox"/> DON'T KNOW

ADDITIONAL INFORMATION

Labs from 3/9/12, except TG - obtained last September with fasting lipids.
Experiencing frequent hypoglycemia.

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** _____