

CKD Diet Counseling (Medical Nutrition Therapy) Referral Form

NAME Harriet Nells **DATE OF BIRTH** 02 | 17 | 1954 **MEDICAL RECORD # (IF APPLICABLE)** 12345

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

Early CKD, blood pressure not at target. Recommended sodium restriction, with lower leg edema present. Recent diagnosis of pre-diabetes. Wants to lose weight.

CKD DIAGNOSTIC CODE 585.3 **OTHER DIAGNOSTIC CODE(S)** 401.9, 790.29

BLOOD PRESSURE 168/105 **WEIGHT** 203 # **HEIGHT** 65 "

RECENT WEIGHT CHANGE? YES NO 8 # **AMOUNT** GAIN LOSS

FOR DIABETICS **YEAR OF DIAGNOSIS** PrDM **A1C** 5.9 **MONTH/YEAR** 12 | 2011

LABORATORY ASSESSMENT *(most recent values)*

ALBUMINURIA NOT PRESENT IF PRESENT, SINCE **MONTH/YEAR** 08 | 2011

UACR *(Urine Albumin-to-Creatinine Ratio)* 65, was 120 **MONTH/YEAR** 12 | 2011

CREATININE 1.2 **eGFR** *(Estimated Glomerular Filtration Rate)* 56 **MONTH/YEAR** 12 | 2011

calculate eGFR

K 4.3 **HCO3** 27.8 **BUN** 16 **Ca** 9.0 **Phos** 4.3 **Hgb** 13.8

LDL 131 **HDL** 37 **TG** 165 **iPTH** pending **Vit D** pending **Alb** 3.6

CURRENT MEDICATIONS *(or attach list)*

Baby aspirin 81 milligrams (mg) daily, simvastatin 20 mg daily, hydrochlorothiazide 25 mg daily, lisinopril 20 mg daily

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 checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> DON'T KNOW
IS THE PATIENT AWARE THAT HE/SHE MAY NEED DIALYSIS?	<input type="checkbox"/> YES	<input checked="" 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

Lab results from 12/1/2011
Family history of diabetes and hypertension

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** _____