REF

WVU Medicine
GARRETT REGIONAL MEDICAL CENTER

OUTPATIENT NUTRITION COUNSELING REFERRAL
FAX TO 301-533-4198

Name_____ DOB_____

Phone(s) _____

Name of Insurance Company **(Attach Copy of Card)** _____

Member ID Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Phone Number for Member Benefits _____

Referring Physician_____

If a minor, name of parent/guardian: _____

Medical Information

Please attach recent labs, history, physical and list of medications and complete the following.

Reason for referral_____ Height_____Weight_____ BMI_____

Physical or cognitive barriers: ☐ Exercise Restriction ☐ Other_____

All follow-up visits will include a follow-up appointment form to justify the order.

- ❑ First Referral for individual Medical/Nutrition counseling in calendar year
- ❑ First Referral for group Medical/Nutrition counseling in calendar year
- ❑ Second Referral for individual Medical/Nutrition counseling in calendar year (**change in Medical Condition, Diagnosis and/or Treatment Plan**)
- ❑ Second Referral for Group Medical/Nutrition counseling in calendar year (**change in Medical Condition, Diagnosis and/or Treatment Plan**)

Please check <u>ALL</u> applicable reasons for referral.

*Traditional Medicare with no supplemental insurance only covers nutrition counseling for diabetes and renal disease.

☐ E10. ___ Type 1 DM*	☐ K50. ___ Crohn's Disease	☐ N18.1 CKD, stage 1
☐ E11. ___ Type 2 DM*	☐ K51. ___ Ulcerative Colitis	☐ N18.2 CKD, stage 2
☐ R73.09 Prediabetes	☐ K58.9 IBS	☐ N18.3 CKD, stage 3*
☐ E66.01 Morbid Obesity (BMI>40)	☐ K86.1 Other Chronic Pancreatitis	☐ N18.31 CKD stage 3a*
☐ E66.09 Obesity (BMI 30-39.9)	☐ K90.0 Celiac Disease	☐ N18.32 CKD stage 3b*
☐ E66.3 Overweight (BMI 25-29.9)	☐ J44.9 COPD	☐ N18.4 CKD, stage 4*
☐ E88.81 Metabolic Syndrome	☐ E28.2 PCOS	☐ N18.5 CKD, stage 5*
☐ R63.4 Abnormal Weight Loss	☐ E78.2 Hyperlipidemia, mixed	☐ Z94.0 Kidney Transplant*
☐ R63.6 Underweight (BMI <18.5)	☐ I10 HTN, essential	☐ N18.6 ESRD on Dialysis
		☐ Other_____ (Include ICD-10 code)

Provider Signature: _____ **Date:** _____