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## Provider Referral Form

The North Country's Premier Nutrition  
& Diabetes Education Firm  
315.783.6810

**Instructions:** Please fax completed form, copy of the patient's most recent lab work, a current progress note, demographic information, and an authorization, if appropriate, to 315.686.4320.

**DATE:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Thank you for your referral! I appreciate your confidence in me and my company to meet your patient's Medical Nutrition Therapy needs. Please circle the diagnosis code and/or diagnosis that you would like the above patient seen for.

Dx	Description	Dx	Description
	<b>Diabetes</b>		<b>Renal Disease</b>
250.0_	Diabetes Mellitus W/out Mention of Comp	403.00	Hyper. Malignant, Stage 1 - IV, or Unspecified
250.1_	Diabetes with Ketoacidosis	403.01	Hyper. Malignant Stage V or End Stage
250.2_	Diabetes with Hyperosmolarity	403.10	Hyper. Benign, Stage 1 - IV, or Unspecified
250.3_	Diabetes with other Coma	403.11	Hyper. Benign, Stage V or End Stage
250.4_	Diabetes with Renal Manifestations	403.90	Hyper. Unspecified, Stage I - IV, or Unspecified
250.5_	Diabetes with Ophthalmic Manifestations	403.91	Hyper. Unspecified Stage V or End Stage
250.6_	Diabetes with Neurological Manifestations	585.1	Chronic, Stage I
250.7_	Diabetes with Peripheral Circulatory Disorder	585.2	Chronic, Stage II (Mild)
250.8_	Diabetes With Other Specified Manifestations	585.3	Chronic, Stage III (Moderate)
250.9_	Diabetes with Unspecified Complications	585.4	Chronic Stage IV (Severe)
648.8_	Other Current Conditions in Mother Class	585.5	Chronic Stage V
	Elsewhere, but complication preg, childbirth or the puerperium, abnormal glucose tolerance	585.6	End Stage Renal Disease
		585.9	Chronic Kidney Disease, Unspecified
	<b>Other</b>	593.9	Unspecified Disorder of Kidney and Ureter
	Obesity		<b>Patient Successful Kidney Transplant</b>
	Hyperlipidemia	V42.0	Organ or Tissue Replaced By Transplant, Kidney
	Food allergy/intolerance		
	Cancer		
	Other: _____		

\_\_\_\_\_ **Need for Diabetes Education:** *I certify that diabetes self-management training services are needed under a comprehensive plan for this patient's diabetes care.*

\_\_\_\_\_ **Authorization Attached**

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Provider's name: \_\_\_\_\_

Contact person: \_\_\_\_\_ Phone: \_\_\_\_\_