Ingrid Knight, RD and Associates, Inc.

Adult and Pediatric Nutrition Counseling

FAX to: 1-855-449-4606

3 Simple Steps to improve the health of your patients

1. Complete referral form 2. Fax 3. We take care of the rest!

Our office: schedules, verifies insurance and keeps you abreast of patient progress

We have Registered Dietitians specializing in:

Weight management, diabetes, high blood pressure, gastrointestinal disorders, sports nutrition, cardiac disease, celiac disease, adult tube feedings, pediatric nutrition and more

Date: _____ Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ Phone: _____

Diabetic: YES ( ) NO ( ) ***if Diabetic or Renal and Medicare, please also complete Medicare referral form**

Referring Physician: _____ Phone: _____

NPI: _____ Fax: _____

INSURANCE COMPANY _____ INS CO PHONE NUMBER _____

SUBSCRIBER NAME _____ SUBSCRIBER'S DATE OF BIRTH _____

ID NUMBER _____ SUBSCRIBER'S RELATIONSHIP TO PT _____

In-network for: BCBS, United Healthcare, Aetna, Humana, Medicare, more.
For all insurances, we check prior authorization, benefits and coverage

MEDICAL DIAGNOSIS (Check all that apply)

☐	E10.___	Type 1 diabetes mellitus	☐	N18.___	Chronic kidney disease, stage ___
☐	E11.___	Type 2 diabetes mellitus	☐	I10	Essential (primary) hypertension
☐	E78.0	Pure hypercholesterolemia	☐	I11.___	Hypertensive heart disease _____
☐	E78.1	Pure hyperglyceridemia	☐	I12	Hypertensive chronic kidney disease
☐	E78.2	Mixed hyperlipidemia	☐	I25	Chronic ischemic heart disease
☐	E78.3	Hyperchylomicronemia	☐	I50	Heart Failure
☐	E78.4	Other hyperlipidemia	☐	K21.0	Gastroesophageal reflux with esophagitis
☐	E78.5	Hyperlipidemia, unspecified	☐	K21.9	Gastroesophageal reflux without esophagitis
☐	E66.0	Obesity due to excess calories	☐	K50.___	Crohn's disease _____
☐	E66.01	Morbid obesity due to excess calories	☐	K57.___	Diverticulosis of _____
☐	E66.3	Overweight	☐	K58	Irritable bowel syndrome (IBS)
☐	E66.8	Other Obesity	☐	K90.0	Celiac disease
☐	E66.9	Obesity, unspecified.- obesity NOS	☐	K52.2	Allergic and dietetic gastroenteritis and colitis
☐		Other	☐		Other

The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.

Athens office:
1551 Jennings Mill Road, Ste 2900A
Watkinsville, GA 30677
Gainesville office:
437 Green Street Place
Gainesville, GA 30501

Call: 404-725-0808
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FAX 1-855-449-4606
Serving Northeast Georgia Communities
www.ingridknightrd.com

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Nutrition Therapy, Consulting

Medicare Referral Form

*please complete along with main referral form

Patient Name: _____ DOB:_____

Medicare provides coverage of Medical Nutrition Therapy (MNT) for beneficiaries diagnosed with diabetes or renal disease (GFR 13-50, except for those receiving dialysis).
MNT provided by a registered dietitian may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

DIAGNOSIS:

☐	E10.___	Type 1 diabetes mellitus	☐	N18.1	Chronic kidney disease, stage 1
☐	E11.___	Type 2 diabetes mellitus	☐	N18.2	Chronic kidney disease, stage 2
☐	O24.410	Gestational diabetes mellitus, diet-controlled	☐	N18.3	Chronic kidney disease, stage 3
☐	O24.414	Gestational diabetes mellitus, insulin-controlled	☐	N18.4	Chronic kidney disease, stage 4
☐		Other	☐	N18.5	Chronic kidney disease, stage 5
			☐	Z94.0	Kidney Transplant Status

Pt to monitor blood glucose _____ times per day.
Is patient cleared to exercise? Yes No

MEDICATIONS _____

LABS/Date: _____
***A1C** _____
HDL _____
LDL _____
CHOL _____
TRIG _____
FBS _____
Weight _____

RENAL LABS:

***GFR:**_____ BUN: _____ Cl:_____ K+: _____ Ca:_____ CRET: ____
Na: _____ Hgb: _____ Alb:_____ Ph: _____ Hct:_____ PAb:_____

Physician Signature: _____ **Date**_____

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