

## Outpatient Nutrition / Diabetes Education Referral Form

Dietitian / Diabetes Educator  
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Patient Name: \_\_\_\_\_ Telephone: home: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ work: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ A1c: \_\_\_\_\_

Comments: \_\_\_\_\_

**DIABETES EDUCATION**

Comments: \_\_\_\_\_

**NUTRITION EDUCATION**

Comments: \_\_\_\_\_

### LEARNING BARRIERS *(please check)*

Visual  Language  Reading  Hearing  Other: \_\_\_\_\_

### DIAGNOSIS *(please check one; diagnosis is required for the referral to be processed)*

**ICD-10**      **Diagnosis Description**

- E78.0      Hypercholesterolemia
- E78.1      Hypertriglyceridemia
- E78.5      Hyperlipidemia
  
- E66.9      Obesity
- E66.01     Morbid Obesity

**ICD-10**      **Diagnosis Description**

- E11.65      Diabetes, Type 2 - uncontrolled
- E10.65      Diabetes, Type 1 - uncontrolled
- 024.419     Gestational Diabetes
- E10.9      Diabetes, Type 1
- E11.9      Diabetes, Type 2
- E88.81      Insulin Resistance Syndrome (X)
- E10.21      Diabetes, Type 1 w/Nephropathy
- E11.21      Diabetes, Type 2 w/Nephropathy
- E11.22      DM with renal complications
- R73.03      Prediabetes

Complication other than what listed, please indicate Diagnosis along with ICD-10 code: \_\_\_\_\_

\*\*\* Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax completed and signed referral form, along with last office visit  
and pertinent labs, to (660) 831-3391.**



REF# NS7211A

Form ID# DIET04  
Rev. Date (12/2017, 12/2018)