



P 0 0 0 1 0

# FOOD AND NUTRITION CERTIFICATE OF MEDICAL NECESSITY FOR OUTPATIENT MEDICAL NUTRITION THERAPY

Bergan Mercy    Mercy Council Bluffs    Immanuel    Lakeside    Midlands

Comments

Name		DOB	Home/Cell Phone	Work Phone
Address		City	State	Zip + 4
Insurance	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Ht	Wt
Physician	Physician Phone		Physician Fax	

### Medical Nutrition Therapy (MNT)

Initial MNT  
 Annual followup MNT  
 Additional MNT services in the same calendar year, per RD recommendations. Please specify change in diagnosis, medical condition, or treatment regimen.

Diagnosis if other than below

- |   |  |
|---|--|
| <input type="checkbox"/> Type I controlled/uncontrolled | <input type="checkbox"/> CKD III IV V  |
| <input type="checkbox"/> Type 2 controlled/uncontrolled | <input type="checkbox"/> IBS           |
| <input type="checkbox"/> Gestational Diabetes           | <input type="checkbox"/> Celiac        |
| <input type="checkbox"/> Pre Diabetes                   | <input type="checkbox"/> GERD          |
| <input type="checkbox"/> Obesity                        | <input type="checkbox"/> Dysphagia     |
| <input type="checkbox"/> Underweight                    | <input type="checkbox"/> Gastroparesis |
| <input type="checkbox"/> Hypertension                   | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Hyperlipidemia                 | <input type="checkbox"/> Food Allergy  |

### Special Needs (check all that apply)

Language    Hearing    Physical/Exercise Limitations  
 Vision    Cognitive Impairment

Other Notes

### Recent Lab

FBS	A1C %	Cholesterol	Triglycerides	HDL
LDL	BUN	Creatinine	Micro-albumin	Potassium/Phosphorus

Physician Signature	Order Date	Expiration Date
---------------------	------------	-----------------

Suggested expiration date six months from initial order date.

**Please FAX to MAC for scheduling (402) 717-2220**