Physician Referral

Complete and Fax To: (800) 957 - 1067

LMG
Lifestyle Medicine Group

1 Patient Information:

Name: _____ DOB: _____ Sex: M / F

Phone: _____ Alt Phone: _____

2 PLEASE ATTACH:

- **A COPY (FRONT AND BACK) OF INSURANCE CARD *REQUIRED**
- **SUPPORTING LAB DATA (A1c, fasting glucose, LDL, HDL, e-GFR)**

Order: ☑ Provide Diabetes Prevention Program or Complete Health Improvement Program (CHIP) by a Registered Dietitian/Registered Health Coach.

3 Diagnosis (Mark the Primary Diagnosis'):

Check	ICD 10 Code	Description	Check	ICD 10 Code	Description
	R73.01	Impaired fasting glucose		E6601	Morbid (severe) obesity
	R73.02	Impaired glucose tolerance (oral)		I10	Essential (primary) hypertension
	R73.09	Other abnormal glucose		I129	Hypertensive renal disease, unspecified
	E119	Diabetes II/unspecified		I2510	Coronary atherosclerosis
	E162	Hypoglycemia, unspecified		N189	Chronic renal failure
	E780	Pure hypercholesterolemia		Z6830 - Z6845	BMI > 30, Patient's BMI _____
	E785	Hyperlipidemia, unspecified		**Other Relevant ICD-10 Codes**	
	E782	Mixed hyperlipidemia			
	E8881	Metabolic syndrome			
	E669	Obesity, unspecified			

Physical Activity Restrictions? YES [ ] NO [ ]; If Yes, limit to:

4 Physician Information:

Name: _____ NPI: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

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