

Viva Real Renal Care

Referral Form

Phone: 815-603-3305. Fax: 505-581-3306. Email: jose.guzmanrdrn@vivarealrenalcare.com

Referring Provider Information:

Name and NPI number: _____

Practice name: _____

Phone/Fax: _____

Email: _____

Patient Demographics:

Full name: _____

DOB: _____

Phone number: _____

Address: _____

Insurance Information:

Primary insurance policy: _____

Policy/Member ID: _____

Referral Diagnosis (Check all applicable diagnoses!):

✓	ICD-10	Diagnosis	✓	ICD-10	Diagnosis
	N18.31	Chronic kidney disease, stage 3a		E10.64	Type 1 diabetes w/hypoglycemia
	N18.32	Chronic kidney disease, stage 3b		E10.65	Type 1 diabetes w/hyperglycemia
	N18.4	Chronic kidney disease, stage 4		E10.9	Type 1 diabetes w/no complications
	N18.4	Chronic kidney disease, stage 5		E11.64	Type 2 diabetes w/hypoglycemia
	R73.03	Prediabetes		E11.65	Type 2 diabetes w/hyperglycemia
	I10	Hypertension		E11.8	Type 2 diabetes w/ no complications
	E78.0	Pure Hypercholesterolemia		Write in	below if ICD-10 not listed:
	E78.5	Hyperlipidemia, unspecified			
	E66.3	Overweight			
	E66.9	Obesity, unspecified			

Additional notes (if necessary):

Consent and Authorization: By submitting this referral, I authorize Viva Real Renal Care to provide nutrition counseling services to the patient listed above and communicate with the referring provider as necessary for care coordination.

Signature: _____ **Date:** _____