KSM

KIDNEY SPECIALISTS

OF MINNESOTA

For the Patient to Keep:

Referral diagnosis(es): _____

Your appointment with the dietitian is on _____

CHECK WITH YOUR INSURANCE TO SEE IF MEDICAL NUTRITION THERAPY IS A COVERED BENEFIT.

- Your insurance may ask for a **Procedure Code**. This is **97802** for the first visit with the dietitian. Visits afterwards are coded **97803**.
- They also will need to know your **Diagnosis.** Your After Visit Summary from today should have the diagnosis. Weight loss counseling may also be covered by some insurance, but you might need to know your BMI. Some will only cover if the BMI is 30 or more. Please call our clinic if you have any questions at 763-561-7337.

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PreVisit Dietitian Questionnaire

Please fill this out and return to KSM prior to your visit with the dietitian.

Name_____

Date of Birth _____

Please allow 90 minutes for your first session. Please fill out this questionnaire as thoroughly as possible and bring it to your appointment. This will allow the dietitian to spend more time answering your questions and developing an individualized plan for you.

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1. Please write down the names and amounts of any nutrition supplements, vitamins, minerals or herbal products you are taking.

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2. Have you already been following some diet restrictions? Please describe:

3. How often do you eat out or get take-out food? What kind of food do you get?

4. Who buys the groceries? _____

   Who prepares the meals? _____

5. Within the past 12 months, you worried that your food would run out before you got money to buy more. *(Select one)*

   [ ] Often true

   [ ] Sometimes true

   [ ] Never true

6. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. *(Select one)*

   [ ] Often true

   [ ] Sometimes true

[ ] Never true.

6. Do you exercise regularly? ____Yes____No

If so, what do you do? _____

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Food Frequency Questionnaire

Please indicate how often you eat the following foods:

	daily or almost daily	a few times a week	a few times a month	a few times a year	Never
Food Item					
Milk, cow's					
Milk, almond, soy, rice, other (circle type)					
Cheese, aged (such as Cheddar, Swiss, Colby)					
Cheese, processed (American, Kraft Singles)					
Cottage cheese					
Yogurt					
Ice cream , frozen yogurt					
Soup (canned, dried, restaurant)					
Soup, home made					
Box convenience mixes (potato, rice, noodle)					
Canned dinners such as chili					
Frozen entrees					
Sausage, Bacon					
Lunchmeats/ deli meats/cured meats					
Hot dogs, bratwurst, Polish sausage					
Pickles, olives					
Chips, pretzels, crackers					
Pizza					
Fast food					
Soda pop: colas					
Iced tea in bottles or cans					
Protein Drinks/Supplements					
Peanut butter or other nut butter					
Nuts of any kind					
Legumes (kidney beans, lentils, black beans, etc.)					
Please also check these items if you have kidney stones:					
Beets					
Navy Beans					
Rhubarb					
Almonds					
Spinach					
Potato with skin					
Rice bran					

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Please write down your usual eating habits. This will help in setting up a meal pattern for you. You can either describe a typical day or write down specifically what you had to eat yesterday or today, if that is easier.

	Food Eaten	**Amount**
Breakfast:		
Snacks:		
Lunch:		
Snacks:		
Supper:		
Snacks:		

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