PLACE ON DIETITIAN'S PRACTICE LETTERHEAD

(Including dietitian name, practice address, contact details and practice number)

Motivation for Medical Nutrition Therapy

Date:

Patients Name:	
Medical Aid:	
Medical Aid Membership No:	**Main member:**
Patient ID:	
Referring doctor and practice number	
Primary ICD-10 code*: Burns T20.2 – T32.9 OR Non-superficial open wounds (any in PMB class 373J, including S21.0 – S99.9 and T01.0 – T01.9 or L89.x OR Other relating to convalescent/rehabilitation care after traumatic injury or major (GIT) surgery	
Secondary ICD-10 codes: ICD-10 codes for any other relevant condition impacting nutritional status or medical nutrition therapy prescription. (e.g. diabetes, hypertension, acute illnesses etc) AND/OR Any other nutrition-related or nutrition-impacting codes e.g. E43, Unspecified severe protein-energy malnutrition AND/OR E46 Unspecified protein-energy malnutrition AND/OR R64 Cachexia [*Note: if using this code then the anthro criteria must support this definition]* R63.4 Abnormal weight loss AND/OR Z68.1 BMI <19 in an adult AND/OR E63 Symptoms concerning food intake AND/OR E63.1 Imbalance of constituents of food intake AND/OR E63.3 feeding difficulties Or any other applicable	

* ***note:*** *for cancer care or palliative care, use the applicable codes/template*

Please approve medical nutrition therapy benefits based on the criteria of [*select/insert/delete applicable]*

- Clinically significant unintentional weight loss **AND/OR**
- The presence of Protein-Energy Malnutrition (PEM) **AND/OR**
- X Symptoms negatively impacting nutrient intake/assimilation, or which increase nutritional losses [*further details must be given as to what these are e.g. anorexia, nausea, vomiting, diarrhoea etc. Ensure above ICD-10 codes match]* **AND/OR**
- Inability to achieve or maintain at least X% of nutritional requirements by the oral route **AND/OR**
- Other clinically relevant rationale [*state rationale with brief explanation]*

Anthropometry:

[*Provide and **interpret** brief anthropometry supporting above selected criteria. Do not include normal values.]*

Biochemistry Assessment

[Provide relevant biochemistry if necessary, if it supports the general motivation]

Clinical Assessment

[Provide BRIEF relevant clinical info if it supports the motivation e.g. outline of extent of wounds/wound losses, trauma rehab, extent of resective bowel surgery etc]

[*Patient Name]* therefore requires [*select/delete as applicable]*:

- Enteral feeding via PEG/nasogastric/PEJ etc because of [*briefly indicate why this is required]*
  AND/OR
- Oral Nutrition Supplementation [*briefly indicate why this is required]*

Nutrition Requirements Calculation

Energy range

Protein range

Fat/CHO range (if applicable)

Fluid range

Deficit in oral intake (if applicable)

Nutritional Prescription

PRODUCT	NAPPI CODE	PACK SIZE	DOSAGE	TOTAL/month or week
ONS Product X			/day	
Enteral Product X			/day	
Glutamed **ZS** Sachets	3000583001	10 x 15g sachets	/day	

Please approve this interim medical nutrition therapy for a period of X months after which I will re-evaluate the clinical circumstances.

Dietetic consultation: X times per month x X months for nutritional monitoring and counselling

Code : 08420X

[Name and signature]