

Referral Form

| | |
|--------------------------|--------------------------------|
| Patient's Name: _____ | Referring Doctor/Clinic: _____ |
| Date of Birth: _____ | Address: _____ |
| Phone/Cell Number: _____ | Phone/Cell Number: _____ |

Diabetes Diagnosis: ICDM

| | |
|---|--|
| <input type="checkbox"/> Type 1 ICD10 E10.65 | <input type="checkbox"/> Gestational ICD10 O99.810 |
| <input type="checkbox"/> Type 2 Controlled ICD10 E11.9 | <input type="checkbox"/> Impaired Glucose Tolerance ICD10 R73.09 |
| <input type="checkbox"/> Type 2 Uncontrolled ICD10 E11.65 | <input type="checkbox"/> Other (not listed) |

Diabetes Self-Management Education/Training (DSME/T)

The patient is to attend the following:

- Comprehensive Management Skills Individual/Group
- (1:1 Assessment and 1:1 follow up at 3, 6 and 9 months. HgbA1c done as needed)
- Complications (Acute) Instruction (1:1)
- Complications (Long-term) Instruction (1:1)
- Insulin Instruction (1:1)
- Insulin Pump Training (1:1)
- Management of Diabetes During Pregnancy
- Self-Blood Glucose Monitoring (1:1)

Medical Nutrition Therapy (MNT)

(1:1) * Referral for MNT must be signed by physician only

- | | |
|--|--|
| <input type="checkbox"/> Initial MNT | <input type="checkbox"/> 3 hours or _____ no. hrs. requested |
| <input type="checkbox"/> Annual follow-up MNT | <input type="checkbox"/> 2 hours or _____ no. hrs. requested |
| <input type="checkbox"/> Additional MNT services in the same calendar year, per RD | |

Diabetic Complications

| | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Dermatopathy | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Retinopathy |
| <input type="checkbox"/> Gastroparesis | <input type="checkbox"/> Nephropathy | <input type="checkbox"/> Other: |

Please fax the following documents at the time of referral:

- Last Doctor's Note
- Most Recent Labs (HgbA1c, Lipid Panel, Comprehensive Metabolic Panel, and Urine Microalbumin/Creatinine)
- List of ALL Medications
- Demographics and Copy of Insurance Card

Progress notes will follow via mail or fax after each visit.

Comments: _____

Referring Physician: _____ Physician's Signature: _____ Date: _____

For Diabetes Education Center Use Only

Patient appointment date: _____ Time: _____ Scheduled for: Individual Group

Comments: _____