

Referral Form

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

Diabetes Diagnosis: ICDM

- | | |
|---|--|
| <input type="checkbox"/> Type 1 ICD10 E10.65 | <input type="checkbox"/> Gestational ICD10 099.810 |
| <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 and Support (DSME/S)

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
- Blood Glucose Monitoring/CGM (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 (OB include prenatal records/ACOGs)
- 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 electronic fax/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: _____