Natividad
Inspiring healthy lives

Diabetes Education Center
1441 Constitution Boulevard, Salinas, CA 93906
Phone (831) 755-6292 | Fax (831) 796-2833
www.natividad.com

Referral Form

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

Diabetes Diagnosis: ICDM

- ❑ Type 1 ICD10 E10.65
- ❑ Type 2 Controlled ICD10 E11.9
- ❑ Type 2 Uncontrolled ICD10 E11.65
- ❑ Gestational ICD10 099.810 (**Due Date**: _____)
- ❑ Impaired Glucose Tolerance ICD10 R73.09
- ❑ Other (not listed)

Medicare Coverage: **DSMES/T** and **MNT** are **separate services**. Individuals may be **eligible for both services** in the same year. Research indicates MNT combined with DSMES/T improves outcomes.

Diabetes Self-Management Education and Support/Training (DSMES/T)

DSMES/T: **medicare coverage** includes 1 hour 1:1 initial DSMES/T in 12-month period from date of first encounter, plus 2 hours follow-up per calendar year with additional signed referral (from MD/DO, APRN, NP or PA) each year.

❑ **ALL** content as related to diabetes care plan and agreed upon by the Patient and DSMES team

OR only specific content areas:

- ❑ Healthy Coping
- ❑ Healthy Eating
- ❑ Being Active
- ❑ Diabetes Management During Pregnancy
- ❑ Reducing Risks
- ❑ Problem Solving
- ❑ Taking Medication
- ❑ Injection Training
- ❑ Insulin Instruction
- ❑ Blood Glucose Monitoring/CGM
- ❑ Other: _____

Medical Nutrition Therapy (MNT)

MNT: **medicare coverage** includes 3 hours initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours with change in medical condition, treatment, and/or diagnosis with signed referral (**from MD/DO only**). Selecting both initial and follow-up MNT allows for additional visits.

❑ Initial MNT (3 hours) ❑ (2 hours) follow-up MNT ❑ Other: _____ hours requested

❑ Additional hours MNT for change in: (choose one) ❑ medical condition ❑ treatment ❑ diagnosis

Referral Requirements

Please fax the following documents at the time of referral. Incomplete referrals will not be processed.

Note: Progress notes will be sent via electronic fax after each visit.

- ❑ Most recent provider notes **(ALL patients)**
  OB referrals: include prenatal records/ACOGs, labs (AIC if available, 2hr/3hr GTT), and documented due date
- ❑ Most recent labs **(ALL patients)**
  HgbA1c, Lipid Panel, Comprehensive Metabolic Panel, and Urine Microalbumin/Creatinine
- ❑ List of ALL current medications **(ALL patients)**
- ❑ Demographics and Copy of Insurance Card **(ALL patients)**
  RAF required for all non-diabetes CCAH patients, HMO plans require pre-authorization

Comments:_____

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

For Diabetes Education Center Use Only

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

Comments: _____