Diabetes Self-Management Education/Medical Nutrition Therapy Referral

Patient's Name (Print): ________________________________ Home Phone #:____________________

Date of Birth:_______/_______/_______ SSN:______________________________

For services to be covered by Medicare, Medicaid, and other insurers, you must specify the following:

Reason For Referral:

- ❑ Diabetes Mellitus Type 2 Uncontrolled (E11.65)
- ❑ Diabetes Mellitus Type 2 Newly Dx (E11.9)
- ❑ Diabetes Mellitus Type 1 Uncontrolled (E10.65)
- ❑ Diabetes Mellitus Type 1 Newly Dx (E10.9)
- ❑ Pre- Diabetes Mellitus (R73.09)
- ❑ Gestational Diabetes (O24.419)
- ❑ Medical Nutrition Therapy

***Referring Diagnosis**: _________________

Education Needs:

- ❑ Initiate Self-Management Education & Training
- ❑ Meal Planning ___________ calories or assessed by RD
- ❑ Oral Medications
  - Name/Dose/Schedule: ____
- ❑ Insulin Therapy
  - Type/Dosage/Schedule: ____
- ❑ Insulin Pump Therapy (Attach Orders)
- ❑ Exercise Restrictions:____

Labs:

Glucose Fasting ___________ Random ___________ HbA1c ___________ Date _______________

CHOL ____________ HDL ____________ LDL ____________ TRIG ____________ Cr. _____________

Learning Barriers: ***If patient needs 1:1 instruction MD must state why.***

❑ Visual	❑ Language	❑ Emotional	❑ Ethnic/Cultural
❑ Hearing	❑ Physical	❑ Mental Status	❑ Religious
❑ Speech	❑ Literacy Level	❑ Cognitive	❑ Medical

Comments: ____

Please Print Physician's Name________________________________ **Phone:**_____________

Physician's Signature____________________________**Date**___________**Time:**_____**am/pm**

To schedule appointments, Call (843) 522-5635 ∆ Fax: (843) 522-5454

Thank you for the referral

Reviewed 12/2018