1609 Park Drive, Traverse City, MI 49686

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##### Referral Form for Diabetes Self-Management Training & Medical Nutrition Therapy

Please Fax completed referral to 231.947.6401

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| **Patient Data:** | **Provider Data:** | | |
| Name: | Name: | | |
| Address: | Address: | | |
| Phone: | Phone: | Fax: | |
| Date of Birth: | ⌦NPI: | ⌦Email: | |
| ⌦Does patient have clearance to exercise?  Yes  No | ⌦Signature: | | ⌦Date: |

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| **Services to be Performed** (please check box below)  Initial DSMT: LIFE with Diabetes   * + Participant assessment and educational plan of care developed with RN,CDE and RD (1 hour individual)   + Group DSMT (six weekly, 2.5 hour group sessions utilizing Stanford Diabetes Self-Management Program curriculum) (11.5 hours group)   + Development of Diabetes Self-Management Support Plan, including follow-up needs   Initial MNT (up to 3 hours)  Additional MNT ⌦No. of extra hours:  ⌦Specify change in medical condition, treatment or dx:    Follow-up (subsequent year) DSMT (up to 2 hours individual)  Follow-up (subsequent year) MNT (up to 2 hours individual)  Pre-Diabetes Education  **Special Need** DSMT is taught as 1 hour individual and the remaining in group setting unless special need is checked below, then all teaching is individual  Vision  Non-ambulatory  Hearing  Cognitive  Language  Other: | **DSMT Content** (please check box/es below)  Content based on assessment of patient’s needs  or only:  Monitoring diabetes  Psychological adjustment  Nutritional management  Medications  Diabetes as disease process  Physical activity  Goal setting, problem solving  Prevent, detect and treat acute complications  Prevent, detect and treat chronic complications  **DSMT/MNT Eligibility** Must provide ONE of these diagnostic criteria   * FBG ≥126 mg/dl on 2 tests:   FBG:       and FBG:   * 2 hr OGTT ≥200 mg/dl on 2 tests   2 hr OGTT:       and 2 hr OGTT:   * Random BG ≥200 mg/dl (with symptoms of uncontrolled diabetes) Random BG: | |
| Excessive thirst  Excessive urination  Excessive hunger  Blurry vision | Excessive tiredness  Unintentional weight loss  Tingling in extremities  Other: |

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| **Primary Diabetes Diagnosis** (please check box below) | ICD-10 | With/Without Complications (please check box below) | ICD-10 |
| Type 1 diabetes mellitus  Type 2 diabetes mellitus  Other abnormal fasting glucose (pre-diabetes)  Other: | E10.\_\_ E11.\_\_  R73.09 | With kidney complications With ophthalmic complications  With neurological complications  With circulatory complications  With other specified complications  With hypoglycemia  With hyperglycemia  With unspecified complications  Without complications | \_\_.2 \_\_.3  \_\_.4  \_\_.5  \_\_.6  \_\_.64  \_\_.65  \_\_.8  \_\_.9 |

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| Lab Work (please attach or complete) | | | | | | | | | Rx Medications (please attach or complete) | | |
| A1C | T-Chol | HDL-C | | LDL-C | TG | BP | | BMI | Diabetes (dose/frequency): | | |
|  |  |  | |  |  |  | |  | Other:  BP  Lipids  Depression/Anxiety  Other: | | |
| Current Treatment Plan (complete as appropriate) | | | | | | | | | | | |
| Target A1C:      % | | | SMBG Schedule (time/frequency): | | | | | | | | |
| Care Manager: | | | | | | | Phone: | | | E-mail: | Fax: |

We look forward to working with you to help your patient manage their diabetes