WVU Medicine

Diabetes Education Center Referral

PHONE: 304-598-4391 FAX: 304-598-4941 PO Box 8241, Morgantown, WV 26506-782

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: _____/_____/_____ Gender: ☐ Male ☐ Female

Address: _____ Phone #: _____

Provider Name: _____ Provider Phone #: _____

Provider Fax #: _____

Diabetes Diagnosis
- ☐ Type 1
- ☐ Type 2
- ☐ Gestational
- ☐ Pre-Diabetes *(Must order MNT)*

Diabetes Medication
- ☐ None
- ☐ Oral Agent
- ☐ Insulin
- ☐ Non-Insulin Injectables

Previous Diabetes Education
- ☐ No
- ☐ Yes
- ☐ Unknown

REASON FOR REFERRAL

- ☐ **Recurrent hyperglycemia**
- ☐ **Recurrent hypoglycemia**
- ☐ **Change in DM treatment regimen**
- ☐ **New Onset Diabetes**
- ☐ **High risk for diabetes related complications**

TYPE OF REFERRAL (CHOOSE ONLY ONE)

MEDICAL NUTRITION THERAPY (MNT)

Choose the type of MNT and number of hours requested

- ☐ **Initial MNT 3 hrs or less:** _____
  - ☐ **Carbohydrate Counting**
  - ☐ **Weight Management for Glucose Control**
  - ☐ **Other** _____
- ☐ **Annual follow up MNT 2 hrs or less:** _____

DIABETES SELF-MANAGEMENT EDUCATION/TRAINING (DSME/T)

Choose the type of DSME/T and number of hours requested

- ☐ **Initial DSME/T 10 hrs or less:** _____
- ☐ **Annual follow up DSME/T 2 hrs or less:** _____

PATIENTS WITH SPECIAL NEEDS (CHECK ALL THAT APPLY)

- ☐ **Vision**
- ☐ **Physical/Dexterity**
- ☐ **Cognitive Impairment**
- ☐ **Language Limitations/Interpreter**
- ☐ **Hearing**
- ☐ **Other** _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

I hereby certify that I am managing this beneficiary's Diabetes condition and this prescribed training is a necessary part of management.

_____ x _____ Date: _____

Provider Name (Printed) Provider Signature