

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

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 ☐ Cognitive Impairment ☐ Hearing
☐ Physical/Dexterity ☐ Language Limitations/Interpreter ☐ 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.

Provider Name (Printed) x Provider Signature

Date: _____