|  |
| --- |
| Patient’s Name: DOB: |
| Address: |
| Daytime Phone: |
| Insurance: Policy #: Prior Auth #: |
| **PLEASE CHECK THE TYPE OF DIABETES SELF-MANAGEMENT TRAINING (DSMT)**  **or MEDICAL NUTRITIONAL THERAPY (MNT) SERVICES** |
| □ INITIAL DSMT, COMPREHENSIVE (10 HRS covering all content areas)  □ FOLLOW-UP DSMT (2 HRS per year following completion of the comprehensive DSMT Program)  □ MEDICAL NUTRITION THERAPY(MNT), INITIAL (3 HRS with RD)  □ FOLLOW-UP MNT (2 HRS per year following completion of initial MNT)  □ SPECIFIC TOPICS & HRS (If needs vary from above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PLEASE CHECK ANY BARRIERS TO GROUP LEARNING OR ADDITIONAL INSULIN TRAINING**  **REQUIRING 1:1 EDUCATION (\*leave blank if none)** |
| □ IMPAIRED MOBILITY □ IMPAIRED DEXTERITY □ IMPAIRED HEARING □ IMPAIRED VISION  □ LEARNING DISABILITY □ IMPAIRED MENTAL/COGNITIVE STATUS □ LANGUAGE BARRIER  □ INSULIN TRAINING □ OTHER (Please Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PLEASE CHECK DIABETES DIAGNOSIS** |
| □ T2DM, UNCONTROLLED □ T2DM, CONTROLLED  □ T1DM, UNCONTROLLED □ T1DM, CONTROLLED  □ GESTATIONAL DM □ DIABETES with PREGNANCY |
| **PLEASE INDICATE PATIENT’S CURRENT THERAPIES, SMBG Schedule, & LABS** |
| □ ORAL/INJECTABLE MEDS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ SMBG (specify frequency):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LABS/DATE: HbA1c:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ FBG: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  BUN:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Cr:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Microalbumin:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ GFR:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  Total Chl:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ HDL:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ LDL:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Trig:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |
| **PLEASE SIGN & DATE** |
| Physician’s Name (printed): Office Phone #:  Office Fax #: |
| Physician’s Signature: Date: |
| \*MNT must be ordered by a MD or DO \*DSMT may be ordered by a MD, DO, or Midlevel Provider |



DIABETES EDUCATION SERVICES REFERRAL FORM

**Diabetes Education Services**

Melanie Campbell, RN, CDE

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