Diabetes Education Services
Melanie Campbell, RN, CDCES
Phone: 989-635-4348
Fax: 989-635-4315

DIABETES EDUCATION SERVICES REFERRAL FORM

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