NUTRITION & DIABETES EDUCATION REFERRAL

Attention Providers: ALL fields must be completed & be legible to be processed.
Call (859) 288-2446 while patient is with you to make appointment, or HAP staff will contact the patient to schedule. **Fax completed form to (859) 899-2271**.

Patient Name: _____ Date of Birth: _____ / _____ /_____
Parent/Guardian: _____ Contact Phone #: _____
Address: _____
Insurance: ☐ None ☐ Medicare* ☐ Private: _____ ☐ MCO Name/#:_____
Language: ☐ English ☐ Spanish ☐ Other: _____
Special Needs that Apply: ☐ Cognitive ☐ Physical ☐ Vision ☐ Hearing ☐ Other: _____

MD's Signature*:_____ *Medicare requires MD sign MNT referrals
MD's Name (*print*): _____ NPI #:_____
Name of Medical Practice: _____
Phone: _____ Fax: _____ Date: _____

MARK TYPE OF SERVICE NEEDED: Patients will be billed for service if not covered by insurance.

☐ **Non-diabetes MNT** (Medical Nutrition Therapy for obesity, lipid management, blood pressure, food allergy, GI disease or other) Please specify need: _____

☐ **Initial Diabetes MNT: 3 hrs total or ____ no. hrs. requested**

☐ **Follow-up Diabetes MNT: 2 hrs total or ____ no. hrs. requested**

☐ **Additional Diabetes MNT services in the same calendar year, per RD ____ no. hrs. requested**

☐ **Advanced Carbohydrate Counting**: Complete the following ***required*** information for this appointment:
Target BG: _____ Correction Factor: _____ Insulin:Carb ratio: _____

☐ **Gestational Diabetes Group class:** Group session with RD and/or RN; taught in Spanish and English

☐ **Additional Insulin/Injectable Medication Training**: Individual session with RN for ☐ Insulin Pen ☐ Vial & Syringe Med name: _____ Dosage: _____

☐ **Group Diabetes Self-Management Education (DSME)** (This series is only offered 3 times a year. *If immediate education desired, please **ALSO** refer to Diabetes MNT and they will be invited to attend DSME when available.)*

Clinical Information – Please fax the following information along with the completed referral:

☑ Most recent progress note ☑ Recent lab report including lipid profile, glucose, A1C ☑ Fasting Glucose(s) at time of diabetes diagnosis, -needed for Medicare compliance.

Diagnosis

☐ E11.9 Type 2 Diabetes, controlled	☐ O24.419 Gestational Diabetes	☐ I10 Hypertension, essential, benign
☐ E10.9 Type 1 Diabetes, controlled	☐ R73.09 Pre-Diabetes	☐ E78.2 Hyperlipidemia
☐ E11.65 Type 2 Diabetes, uncontrolled	☐ E16.2 Hypoglycemia, reactive	☐ E66.01 Morbid Obesity
☐ E10.65 Type 1 Diabetes, uncontrolled	☐ N18.___Chronic Kidney Dz	☐ Other: _____

Exercise Restrictions? **NO** or **YES** If yes, explain:_____

Appt. Date/Time:_____ _____

Health Dept Use Only: Pt call #1: Pt call #2: Pt letter mailed: Pt. Reminder? ☐ YES