NUTRITION & DIABETES EDUCATION REFERRAL

Healthy Action Plan Clinic

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 and arrange for appointment. **Fax completed form to (859) 899-2271.**

Patient Name: _____ Date of Birth: _____ / _____ /_____

Parent/Guardian: _____ Contact Phone #: _____

Address: _____

Insurance: ☐ None ☐ Medicare* ☐ Private: _____ ☐ MCO Name/#:_____

**Medicare requires a MD signature on MNT referrals* Language: ☐ English ☐ Spanish ☐ Other: _____

Referring MD's Signature*: _____ Date: _____

Referring MD's Name (*print*): _____ NPI #: _____

Name of Medical Practice: _____

Address: _____

Phone: _____ Fax: _____

Mark Type of Service Needed: $10 charge may apply if not covered by insurance.

Group Classes:	
☐ **Diabetes Basics Group Class**	☐ **Diabetes Self-Management Group Class**
Individual Appointments:	
Check Special Needs that Apply: ☐ Cognitive ☐ Physical ☐ Vision ☐ Hearing ☐ Other: _____	
☐ **Medical Nutrition Therapy** (nutrition counseling for diabetes, obesity, high cholesterol, blood pressure, food allergy, GI disease, or other) Please specify need: _____	
☐ **Advanced Carbohydrate Counting**: Target BG: _____ Correction Factor: _____ Ratio: _____	
☐ **Insulin or Injectable Medication Instruction**: Check one: ☐ Insulin Pen ☐ Vial and Syringe Med Name: _____ Dosage: _____	

Clinical Information – Please complete below or fax the most recent labs and last progress note.

TChol: _____ HDL: _____ LDL: _____ Triglycerides: _____ A1C: _____ Other: _____

Diagnosis

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

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

Appt. Date/Time:_____ _____

Health Dept Use Only: Patient Contacted: ☐ By Phone ☐ By Letter Appointment Entered ☐ YES Pt. Reminder? ☐ YES

If a patient does not respond to HAP provider in 30 days this referral will be destroyed. ***LHD-608***