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 our staff will contact the patient to schedule. **Fax completed form to (859) 899-5221**.

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

Updated 8/2019

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