

# 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) 899-5235.**

Patient Name: _____	Date of Birth: ____/____/____
Parent/Guardian: _____	Contact Phone #: _____
Address: _____	
Insurance: <input type="checkbox"/> None <input type="checkbox"/> Medicare* <input type="checkbox"/> Private: _____ <input type="checkbox"/> MCO Name/#: _____	
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Special Needs that Apply: <input type="checkbox"/> Cognitive <input type="checkbox"/> Physical <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Other: _____	
MD's Signature*: _____ *Medicare requires MD sign MNT referrals	
MD's Name ( <i>print</i> ): _____ NPI #: _____	
Name of Medical Practice: _____	
Phone: _____	Fax: _____ Date: _____

<b>MARK TYPE OF SERVICE NEEDED: Patients will be billed for service if not covered by insurance.</b>
<input type="checkbox"/> <b>Non-diabetes MNT</b> (Medical Nutrition Therapy for obesity, lipid management, blood pressure, food allergy, GI disease or other) Please specify need: _____
<input type="checkbox"/> <b>Initial Diabetes MNT: 3 hrs total or ____ no. hrs. requested</b>
<input type="checkbox"/> <b>Follow-up Diabetes MNT: 2 hrs total or ____ no. hrs. requested</b>
<input type="checkbox"/> <b>Additional Diabetes MNT services in the same calendar year, per RD ____ no. hrs. requested</b>
<input type="checkbox"/> <b>Advanced Carbohydrate Counting:</b> Complete the following <i>required</i> information for this appointment: Target BG: _____ Correction Factor: _____ Insulin:Carb ratio: _____
<input type="checkbox"/> <b>Gestational Diabetes Group class:</b> Group session with RD and/or RN; taught in Spanish and English
<input type="checkbox"/> <b>Additional Insulin/Injectable Medication Training:</b> Individual session with RN for <input type="checkbox"/> Insulin Pen <input type="checkbox"/> Vial & Syringe Med name: _____ Dosage: _____
<input type="checkbox"/> <b>Group Diabetes Self-Management Education (DSME)</b> (This series is only offered 3 times a year. <i>If immediate education desired, please ALSO refer to Diabetes MNT and they will be invited to attend DSME when available.</i> )

**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**

<input type="checkbox"/> E11.9 Type 2 Diabetes, controlled	<input type="checkbox"/> O24.419 Gestational Diabetes	<input type="checkbox"/> I10 Hypertension, essential, benign
<input type="checkbox"/> E10.9 Type 1 Diabetes, controlled	<input type="checkbox"/> R73.09 Pre-Diabetes	<input type="checkbox"/> E78.2 Hyperlipidemia
<input type="checkbox"/> E11.65 Type 2 Diabetes, uncontrolled	<input type="checkbox"/> E16.2 Hypoglycemia, reactive	<input type="checkbox"/> E66.01 Morbid Obesity
<input type="checkbox"/> E10.65 Type 1 Diabetes, uncontrolled	<input type="checkbox"/> N18.____ Chronic Kidney Dz	<input type="checkbox"/> 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