Physician Referral Form

Diabetes Self-Management Education (DSME), and Medical Nutrition Therapy (MNT), or Diabetes Prevention Program (DPP)

Referring Physician Information

Referring Physician ______________________ NPI # ______________ License # ______________________

Address ______________________ City ______________ State __________ Zip ____________

Office Phone ______________________ Fax ______________

Patient Information

Patient Name ____ Date of Birth ___/___/___ Sex ❑ M ❑ F
Last *First* *MI*

Address ______________________ City ______________ State __________ Zip ____________

Email ______________________ Phone ______________ Cell Phone ______________________

Patient Medical Information

(Please send progress notes, medication list, lipid panel, HbA1c)

Insurance Information *(Attach copy of insurance)*

Primary Insurance Provider ______________________ Secondary Insurance Provider ______________________

Authorization Required ❑ Yes ❑ No Auth # ______________________

Diagnosis

ICD-10 Code *(required)* ______________________

❑ Type 1 Diabetes ❑ New Diagnosis
❑ Type 2 Diabetes
❑ Impaired Fasting Glucose (Pre-Diabetes)
❑ Other ____________

Medicare coverage: 10 hrs initial DSME in 12 month period from the first date visit.

❑ 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually. ❑ Additional MNT 3 hrs for change in medical condition, treatment and/or lack of understanding of diabetes diet.

Services *(Check applicable services)*

❑ Blood Glucose Meter Training
❑ Insulin Pump Therapy
❑ Continuous Glucose Monitoring (CGM)
❑ Recommendations for Adjustment of Insulin Basal and Bolus Therapy
❑ Recent Changes in Diabetes Medications
❑ Recurrent Hypoglycemia
❑ Carbohydrate Counting
❑ Annual Follow-Up
❑ Insulin or Injectable Diabetes Medication Training Name ______________________ Dose __________ Time ______
❑ Fasting Blood Glucose Parameters ______________ *(ADA Recommendations: 80-130 mg/dl before meals)*
❑ High Risk for Complications Due to Diabetes/Co-Morbid Conditions:

❑ Retinopathy ❑ Neuropathy ❑ Nephropathy ❑ Gastroparesis
❑ Hyperlipidemia ❑ Hypertension ❑ Cardiovascular Disease ❑ Other ____________

❑ Other Patient Needs ____

Does the patient have any special needs/limitations to receive individual instruction? *(Check all that apply)*

❑ Visual ❑ Hearing ❑ Physical ❑ Language ❑ Other ______________________

PCOT Hgb A1c will be performed at the start and at completion of the program within 3-4 months if not available.

I certify the above patient requires diabetes education to provide therapy compliance and to provide him/her with the skills and knowledge to help manage their diabetes.

Physician Signature ________________________________ Date ____________ Time ____________

(DSME can be ordered by an MD, DO or mid-level provider managing the patient's diabetes.)
(MNT must be ordered by MD or DO only)

(For Diabetes Office Use Only)

EISENHOWER MEDICAL CENTER
39000 Bob Hope Dr., Rancho Mirage, CA 92270
PROBST BLDG. – SUITE 100-B | PHONE: 760-773-1403 | FAX: 760-773-1880

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