

Legacy Diabetes and Nutrition Education

Physician Referral Form



Please complete this form, print and sign, then fax to the appropriate location:

- | | | | | | | | |
|---|--|--|---|--|--|---|---|
| <input type="checkbox"/> Mount Hood*
Phone: 503-674-1254
Fax: 503-674-1267 | <input type="checkbox"/> Emanuel*
Phone: 503-413-2750
Fax: 503-413-2735 | <input type="checkbox"/> St. Helens
Phone: 503-397-0471
Fax: 503-366-3014 | <input type="checkbox"/> Salmon Creek*
Phone: 360-487-2727
Fax: 360-487-2729 | <input type="checkbox"/> Good Samaritan
Phone: 503-413-7227
Fax: 503-413-6888 | <input type="checkbox"/> Meridian Park*
Phone: 503-692-7791
Fax: 503-692-7788 | <input type="checkbox"/> Randall Children's*
Phone: 503-413-1600
Fax: 503-413-1915 | <input type="checkbox"/> Woodburn/Silverton*
Phone: 971-983-5212
Fax: 503-944-6813 |
|---|--|--|---|--|--|---|---|

*A hospital based department

Patient information

Last name _____ First name _____ Middle initial _____
Date of birth _____ Home phone _____ Other phone _____ Insurance _____

Diagnosis (please include ICD-10 code if not listed)

- | | | |
|--|---|--|
| <input type="checkbox"/> Type 2 DM – E11.9 | <input type="checkbox"/> Hyperlipidemia unspecified – E78.5 | <input type="checkbox"/> Abnormal glucose – R73.09 |
| <input type="checkbox"/> Type 2 Uncontrolled – E11.65 | <input type="checkbox"/> Hypertension – I10 | <input type="checkbox"/> Polycystic Ovarian Syndrome – E28.2 |
| <input type="checkbox"/> Type 1 DM – E10.8 | <input type="checkbox"/> Gestational Diabetes – O24.419 | <input type="checkbox"/> Celiac Disease – K90.0 |
| <input type="checkbox"/> Type 1 Uncontrolled – E10.65 | <input type="checkbox"/> Pregnancy w/pre-existing DM | <input type="checkbox"/> GI Disorder _____ (please include ICD-10) |
| <input type="checkbox"/> Impaired Glucose Tolerance – R73.02 | <input type="checkbox"/> 1st trim – 024.911 | <input type="checkbox"/> Cancer _____ (please include ICD-10) |
| | <input type="checkbox"/> 2nd trim – 024.912 | |
| | <input type="checkbox"/> 3rd trim – 024.913 | |

Date of diagnosis _____

Secondary Diagnoses:

- Overweight – E66.3
 Obesity – E66.9
 Morbid Obesity – E66.01
 Other _____
(please include ICD-10) _____

→ **Important! Please FAX recent progress notes, problem list, pertinent labs (A1c, Lipids, 3-HR GTT, other) and list of medications (required by The Joint Commission).** (Not necessary if patient record is in Legacy EMR)

Diabetes self-management training (Non-diabetes nutrition counseling is provided in individual sessions)

Medicare will cover individual Diabetes Education only if one of the following is documented by the referring provider:

- | | | |
|---|---|--|
| <input type="checkbox"/> Language barrier – Interpreter needed for (give language) _____ | <input type="checkbox"/> Hearing impaired | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Learning difficulties – Describe _____ | <input type="checkbox"/> Vision-impaired _____ | |

Group classes include diabetes self-care skills, healthy eating, role of exercise and avoiding complications. Follow-up one month later assesses achievement of established personal diabetes self-care goals.

- Comprehensive Course (DSMT) — Type 2** (up to 10 hours)
Includes 1:1 assessment and MNT (medical nutrition therapy)
- Children's Comprehensive Course (DSMT) — Type 1**
(new onset)
- Insulin Start**
Type and dose (no abbreviations): _____

Educator may make adjustments per protocol

- Yes No

Target Blood Glucose

- ADA Standards** Fasting: 80–130; 2-hr pp: <180
- Other:** _____

- Medical Nutrition Therapy (MNT)** (1–3 hours) Topics such as hyperlipidemia, GI issues, PCOS, etc. (state topic and ICD-10)
- Pregnancy Issues**
Gestational diabetes or pregnancy with pre-existing diabetes. Monitoring, dietary and insulin considerations.
- Diabetes Refresher — Type 1 or 2**
Focused self-care topics such as healthy eating, blood glucose monitoring, role of exercise and avoiding complications.
- Intensive Management — Type 1 or 2**
Includes assessment, carbohydrate counting, insulin adjustment as needed and plan for tighter blood glucose control.
- Insulin Pump Series**
Includes assessment, pump start, insulin adjustment and follow-up.
- Continuous Glucose Monitoring Sensor**
Sensor start, download and interpretation

Please mark interpreter preference: Educator M.D.

Referring provider authorization

As the health care provider managing this patient's diabetes care, I certify that this training is needed to ensure therapy compliance and provide the necessary skills and knowledge to enable the patient to manage his/her condition.

Referring provider

Name _____ Clinic _____ Phone _____ Fax _____
Primary care provider (if different) _____ Clinic _____ Phone _____ Fax _____
Physician signature _____ Date _____