LEGACY DIABETES & NUTRITION SERVICES
EDUCATION REFERRAL FORM

☐GOOD SAMARITAN	☐ MERIDIAN PARK	☐ MOUNT HOOD	☐ EMANUEL	☐ ST HELENS	☐ WOODBURN	☐ SALMON CREEK	☐CHILDREN'S HOSP
TEL: 503-413-7227	TEL: 503-692-7791	TEL: 503-674-1254	TEL: 503-413-2750	TEL: 503-397-0471	TEL: 503-981-9526	TEL: 360-487-2727	TEL: 503-413-1600
FAX: 503-413-6888	FAX: 503-692-7788	FAX: 503-674-1267	FAX: 503-413-2735	FAX: 503-366-3014	FAX: 503-982-3814	FAX: 360-487-2729	FAX: 503-413-1915

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

DOB: / /	TEL: H ( )	W ( )	INSURANCE

REFERRING PROVIDER INFORMATION

NAME	CLINIC	TEL	FAX
PCP (IF DIFFERENT)	CLINIC	TEL	FAX

DIAGNOSIS (please include ICD9 code if not listed) — DATE OF DIAGNOSIS:

☐TYPE 2 DM – 250.00	☐HYPERLIPIDEMIA W/O DIABETES – 272.0	☐METABOLIC SYNDROME – 277.7	**SECONDARY DIAGNOSES:**
☐TYPE 2 UNCONTROLLED – 250.02	☐HYPERTRIGLYCERIDEMIA – 272.1	☐POLYCYSTIC OVARIAN SYNDROME – 256.4	☐OVERWEIGHT – 278.02
☐TYPE 1 DM – 250.01	☐HYPERTENSION – 401.1	☐CELIAC DISEASE – 579.0	☐OBESITY – 278.00
☐TYPE 1 UNCONTROLLED – 250.03	☐GESTATIONAL DIABETES – 648.83	☐GI DISORDER _____ **(Please specify ICD9)**	☐MORBID OBESITY – 278.01
☐IMPAIRED GLUCOSE TOLERANCE – 790.29	☐PREGNANCY W/PRE-EXISTING DM – 648.03	☐CANCER – _____ **(Please specify ICD9)**	☐OTHER – _____ **(Please specify ICD9)**

➔ **IMPORTANT! PLEASE FAX RECENT PROGRESS NOTES, PROBLEM LIST, PERTINENT LABS (A_1c, LIPIDS, 3-HR GTT, OTHER) AND LIST OF MEDICATIONS (REQUIRED by 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:**

☐**Language barrier** – Interpreter needed for (give language) _____

☐ **Hearing impaired**

☐ **Vision-impaired**

☐**Learning difficulties –** Describe _____

☐ **Other** (PLEASE SPECIFY) _____

☐**COMPREHENSIVE COURSE (DSMT)** – Type 2 (10 hours)
Includes 1:1 assessment. **IF YOUR PATIENT HAS MEDICARE, PLEASE ALSO MARK MEDICAL NUTRITION THERAPY.**

☐**CHILDRENS COMPREHENSIVE COURSE (DSMT)** – Type 1 (NEW ONSET)
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.

☐**INSULIN START** (2-4 hours)
Give type and dose (*no abbreviations*) _____
_____
_____

Continue on oral agent? ☐**YES** ☐**NO**
Specify Changes:_____

EDUCATOR MAY MAKE ADJUSTMENTS PER PROTOCOL
☐**YES** ☐**NO**

☐ **MEDICAL NUTRITION THERAPY (MNT)** for *Medicare diabetes and Medicare renal patients only* – (first year 3 hours; subsequent years 2 hours)

☐ **DIABETES REFRESHER – TYPE 1 or 2** (2-4 hours) Review of general or indicated self-care topics such as healthy eating, blood glucose monitoring, role of exercise, and avoiding complications.

☐ **INTENSIVE MANAGEMENT—TYPE 1 OR 2** (4-6 hours)
Includes carbohydrate counting and individual assessment and plan for tighter blood glucose control.

☐ **CONTINUOUS GLUCOSE SENSOR** (1-3 hours)
Includes sensor start and sensor download and interpretation
Please mark interpreter preference EDUCATOR ☐ MD ☐
SENSOR DAYS PREFERRED (Circle one) 3 4 5 Other_____

☐ **PREGNANCY ISSUES** (2-3 hours)
Gestational diabetes or pregnancy with pre-existing diabetes. Includes dietary consultation, monitoring, insulin considerations

☐ **FOCUSED NUTRITION EDUCATION**, **(MNT)**, (1-3 hours) Topics such as cholesterol management, GI issues, PCOS, etc. (State topic)
_____

REFERRING PROVIDER AUTHORIZATION

As the healthcare 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.

PROVIDER SIGNATURE_____DATE_____