Legacy Diabetes and Nutrition Education

Physician Referral Form

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

☐ **Good Samaritan**	☐ **Meridian Park**	☐ **Mount Hood**	☐ **Emanuel**	☐ **St. Helens**	☐ **Salmon Creek**	☐ **Randall Children's**
Phone: 503-413-7227	Phone: 503-692-7791	Phone: 503-674-1254	Phone: 503-413-2750	Phone: 503-397-0471	Phone: 360-487-2727	Phone: 503-413-1600
Fax: 503-413-6888	Fax: 503-692-7788	Fax: 503-674-1267	Fax: 503-413-2735	Fax: 503-366-3014	Fax: 360-487-2729	Fax: 503-413-1915

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)*

Date of diagnosis ______________

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

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:

- ☐ **Language barrier** – Interpreter needed for *(give language)* ______________________________
- ☐ **Learning difficulties** – Describe ______________________________
- ☐ **Hearing-impaired**
- ☐ **Vision-impaired**
- ☐ **Other** *(please specify)* ______________________________ ______________________________

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 ____________

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