

***Starred items are required for patient to schedule an appointment**

*Patient Name: _____ *DOB: _____
 Patient contact numbers - Home : _____ Cell : _____ Work : _____

* Please specify diagnosis (check all that apply)				Fax : 425-688-5710	Phone: 425-688-5700 (Select option 5)
<input type="checkbox"/> Type 1 Diabetes	<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Renal insufficiency	<input type="checkbox"/> Cancer Type: _____		
<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Type 2, Insulin treated	<input type="checkbox"/> Chronic renal failure	<input type="checkbox"/> Irritable Bowel Syndrome		
Diabetes Complications:		Note: MNT for CRF reimbursed by Medicare if: GFR 13 - 50mL/ min, not on dialysis		<input type="checkbox"/> Celiac Disease	
<input type="checkbox"/> Renal	<input type="checkbox"/> Ophthalmic	<input type="checkbox"/> Hypoglycemia, in absence of diabetes	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Dysphagia	
<input type="checkbox"/> Pregnancy, complicated by preexisting DM	<input type="checkbox"/> Peripheral circulatory	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Weight management	<input type="checkbox"/> Unplanned weight loss	
<input type="checkbox"/> Neurological	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Pre-Diabetes	<input type="checkbox"/> Malnutrition	<input type="checkbox"/> Bariatric surgery	
		<input type="checkbox"/> Metabolic Syndrome	<input type="checkbox"/> Pre <input type="checkbox"/> Post Type: _____		
		<input type="checkbox"/> Hyperlipidemia			
		<input type="checkbox"/> PCOS	Surgery Date: _____		
		<input type="checkbox"/> Other: _____			

DIABETES EDUCATION (Check education requested)	MEDICAL NUTRITION THERAPY (MNT) (Provided by a Registered Dietitian)
<input type="checkbox"/> Diabetes self-management training: (topics include: diabetes disease process, monitoring/ using results, goal setting/ problem solving, nutrition, acute complications, chronic complications, medications, physical activity and psychosocial adjustment; <i>preconception care, pregnancy and GDM when applicable</i>) *Please check one: <input type="checkbox"/> Class (Required by Medicare) <input type="checkbox"/> Individual <i>Medicare requires individual training due to the following impairment:</i> <input type="checkbox"/> vision <input type="checkbox"/> hearing <input type="checkbox"/> mobility <input type="checkbox"/> language <input type="checkbox"/> cognitive <input type="checkbox"/> other: _____ <input type="checkbox"/> Follow-up diabetes self-management training <input type="checkbox"/> Insulin training <input type="checkbox"/> Insulin brand/ type: _____ Dose: _____ <input type="checkbox"/> Diabetes nurse practitioner to prescribe insulin regimen <input type="checkbox"/> Insulin pump initiation/ training Pump: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Nutrition counseling (<i>for diagnosis noted above</i>) <input type="checkbox"/> Initial assessment and follow-up <input type="checkbox"/> Ongoing care - Referral renewal MNT for Medicare Beneficiary <u>Nutrition Education to Manage Diabetes</u> <input type="checkbox"/> Initial assessment and follow-up, 3 hours OR <input type="checkbox"/> 2 hours follow-up subsequent year <u>Nutrition Education to Manage CRF</u> Renal disease with GFR 13 - 50 mL/ minute (non-dialysis) <input type="checkbox"/> Initial assessment and follow-up, 3 hours OR <input type="checkbox"/> Follow-up subsequent year, 2 hours <input type="checkbox"/> Request for additional diabetes education or CRF MNT hours Specify: number of hours _____ (2 hours maximum allowed) Specify: change in condition, diagnosis, treatment: _____ _____

Pertinent Laboratory Values: See attached Available in Meditech
 Draw date: _____ HgbA1c: _____% Fasting blood glucose: _____ BUN: _____ mg/ dl Creatinine: _____mg/ dl
 Total cholesterol: _____ LDL: _____ HDL: _____ Triglycerides: _____
 Other: _____
 If recent labs are not available, may we perform at patient's visit? Yes No

I certify that I am managing the beneficiary's selected medical diagnosis and the training described above is needed to ensure therapy compliance, or to provide the beneficiary with the skills and knowledge to help manage their condition.

 *Referring Provider's Name (Printed)

 *Physician Signature

 *Date

 *Time



OUTPATIENT DIABETES & NUTRITION
REFERRAL/ ORDERS
 P0230A (Rev 0309)