Wilkes Diabetes Self Management Program
REFERRAL FORM

Patient's Name _____ Physician Name: _____
DOB _____ Phone#:_____ Practice: _____
Address: _____ Practice Phone #: _____
Insurance: _____ Practice Fax #: _____

Diabetes Diagnosis

☐Type1, controlled ☐Type1, uncontrolled ☐Type 2, controlled ☐Type 2, uncontrolled ☐Gestational
☐Pre-Existing DM with Pregnancy ☐Pre-diabetes ☐Other_____

Education Needed

☐ BOTH Group Diabetes Education & Medical Nutrition Therapy
Checking BOTH allows for maximum patient contact hours and best patient outcomes
☐ Group Diabetes Education
☐ Medical Nutrition Therapy (MNT)
☐ Individual Diabetes Education **(Medicare requires a reason listed for Individual Diabetes Education)**
☐Vision ☐ Hearing ☐Physical ☐ Cognitive impairment ☐ Psychosocial impairment
☐Language barrier ☐ Impaired mental status/cognition ☐ Eating disorder
☐ Learning disability ☐Other (please specify)_____
☐ Gestational Diabetes Education

Complication/ Comorbidities - Check all that applies

☐ Retinopathy ☐Neuropathy ☐ Nephropathy ☐ Gastroparesis ☐ Non-healing wound ☐Stroke
☐ Hyperlipidemia ☐ Hypertension ☐ Cardiovascular disease ☐Chronic Renal Insufficiency ☐ PVD
☐ **Other** _____
_____

Medications

☐ Attached (FAX medication list) OR list meds below:
☐Oral Agents: _____
☐ Insulin _____
Other pertinent medications _____

Labs	Results	Date
HBA1C	_____	_____/_____/_____
Total Cholesterol	_____	_____/_____/_____
LDL	_____	_____/_____/_____
HDL	_____	_____/_____/_____
Triglycerides	_____	_____/_____/_____
Microalbumin	_____	_____/_____/_____

Age _____
Height _____
Weight _____

Exercise Restrictions: ☐ None ☐ Yes, list:
_____

Provider Signature: (Required) _____ **Date** _____
(Medicare requires MD signature for MNT services)

Fax Referral Form to: 336-667-1065 Questions? Call Jennifer Miller (Office Manager) 336-667-0460
8/12; 6/13

Wilkes Diabetes and Nutrition Center
Medical Nutrition Therapy
Referral Form for adults, teens and pediatrics

Medical Nutrition Therapy (MNT) **All services provided by a Registered Licensed Dietitian**
(Check services being ordered)

□ **MNT**

□ **Additional MNT services in the same calendar year per RD recommendations**

Please specify change in diagnosis, medical condition or treatment regimen:_____
_____
_____

DIAGNOSIS

□250.00 Type II Diabetes, unspecified
□250.02 Type II Diabetes, uncontrolled
□250.01 Type I Diabetes, unspecified
□250.03 Type I Diabetes, uncontrolled
□ 790.29 Pre-diabetes
□ 648.80 Gestational Diabetes
□ Chronic Kidney Disease (please circle ICD-9 code)
585.1, 585.2, 585.3, 585.4, 585.5, 585.6, 585.9
□ Post Kidney Transplant
□ 272.00 Hyperlipidemia
□ 401.9 Hypertension
□ 251.1 Hyperinsulinism

□ 278.00 Obesity, unspecified
□ 783.22 Underweight
□ 278.01 Morbid Obesity
□ 277.7 Metabolic Syndrome
□ 783.10 Abnormal weight gain excludes obesity
□ V23.7 High Risk Pregnancy; insufficient prenatal care
□ V23.81 Other High Risk Pregnancy; elderly primigravida
□ Other Diagnosis/code:_____
_____
_____
_____

Pertinent Medications:
_____
_____
_____
_____

Labs/ Data **Age_____** **Ht_____** **Wt_____**

	Results	Date
HbA1C	_____	_____
Total Cholesterol	_____	_____
HDL	_____	_____
LDL	_____	_____
Triglycerides	_____	_____
GFR	_____	_____
Other	_____	_____

Exercise Restrictions: _____None _____ Yes, list:
_____
_____
_____

Other Special Instructions/Behavioral Goals or Plans:
_____
_____
_____

Provider Signature: (Required) _____ **Date** _____
(Medicare requires MD signature for MNT services)

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