

**TO SCHEDULE: CALL 888-844-0080 and FAX completed / signed referral form to 336-718-9270**

*Please print:*

Name: \_\_\_\_\_ SS # \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ DOB \_\_\_\_\_  
 Insurance(s): \_\_\_\_\_  
 (please fax copy of insurance information)

**Language Spoken other than English**  Spanish  Other \_\_\_\_\_

<p><b>Diabetes Diagnosis:</b>  <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2: <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled  <input type="checkbox"/> Gestational (weeks gestation _____)  <input type="checkbox"/> Pre-existing diabetes &amp; pregnancy (weeks. gestation _____)  <input type="checkbox"/> Impaired Glucose Tolerance, Impaired Fasting Glucose, Metabolic Syndrome  <input type="checkbox"/> Other _____</p>	<p><b>Patient has special needs to receive individual instruction. (Check all that apply)</b>  <input type="checkbox"/> Vision <input type="checkbox"/> Hearing  <input type="checkbox"/> Physical <input type="checkbox"/> Cognitive  <input type="checkbox"/> Language limitations <input type="checkbox"/> Other _____</p>
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**Most recent relevant lab results:** *We must have relevant lab results prior to meeting with your patient!*

**Date** \_\_\_\_\_ **(Please fill in blanks or fax relevant labs)**

Cholesterol _____	Triglycerides _____	HgbA1c _____
HDL _____	B/P _____	Glucose _____
LDL _____	Other _____	

**GTT results for GDM or if applicable**

**Date** \_\_\_\_\_ **Fasting** \_\_\_\_\_ **1hr** \_\_\_\_\_ **2hr** \_\_\_\_\_ **3hr** \_\_\_\_\_

**Complications / Co-Morbidities (check all that apply):**

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Renal Failure (list restrictions) _____
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Retinopathy
<input type="checkbox"/> Celiac	<input type="checkbox"/> Foot problems	<input type="checkbox"/> Nephropathy	<input type="checkbox"/> Tube Feedings
<input type="checkbox"/> CVD	<input type="checkbox"/> Gastric Bypass Pre/Post	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Under Weight / Malnourished
<input type="checkbox"/> Depression	<input type="checkbox"/> Gastroparesis	<input type="checkbox"/> Obesity: Pediatric / Adult	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> GI Disorders _____	<input type="checkbox"/> Pregnancy	

**Plan of Care / MD Orders**

**\*Diabetes Self Management Training (DSMT)**

<input type="checkbox"/> Initial training (includes 1 hour assessment and either 9 hr Comprehensive or 4 hr Basics class based on patient needs)	
<input type="checkbox"/> Follow-up training: (For patients who have had DSMT and need reassessment/further training) Identify need: _____	
<input type="checkbox"/> Gestational Diabetes/Diabetes and Pregnancy	<input type="checkbox"/> Insulin Pump Training (overview of pump therapy and patient evaluations)
<input type="checkbox"/> Individual Instruction (describe)	<input type="checkbox"/> Insulin Pump Initiation/Start: Initial Order _____
<input type="checkbox"/> <b>Diabetes Prevention Class(Pre-DM, IGT, IFG)</b>	<input type="checkbox"/> Glucose Sensor Training (patient owned sensor) _____
<input type="checkbox"/> <b>Glucose Monitoring, Continuous (72 Hr. CGMS)</b>	<input type="checkbox"/> Insulin Administration: Initial Order _____

**\*\*Medical Nutrition Therapy (MNT)**

**Diabetes Specific:**

Initial MNT  
 Additional MNT  
 Annual follow-up MNT - Specify change in Dx, medical condition, or treatment regiment: \_\_\_\_\_

**Non-Diabetes Specific MNT (please fill in each section below)**

MNT visit:/Primary Diagnosis/Reason for Visit \_\_\_\_\_  
 . Nutrition Prescription/Order: \_\_\_\_\_  
 **or check if RD, LDN to determine**

*\*Medicare allows 10 hrs. initial in 12 month period, plus 2 hrs follow up annually  
 \*\* Medicare allows 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually.  
 Additional MNT hours available for change in medical condition, treatment and/or diagnosis.*

**Desired Outcomes for DM Patients:**

HgbA1c \_\_\_\_\_  B/P \_\_\_\_\_  LDL \_\_\_\_\_

**Patient Behavioral Goals:**

**I hereby certify that I am managing this beneficiary's Diabetes condition and/or Medical Nutrition Therapy and that the above prescribed training is a necessary part of management.(Medicare patients)**

<b>MD Name (Please Print)</b>	<b>MD, DO, PA, NP Signature</b>	<b>Date/Time</b>
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<b>Group Practice Name</b>	<b>(Phone)</b>	<b>(Fax)</b>
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DIABETES AND NUTRITION SERVICES

**Winston-Salem Referral**

**TO SCHEDULE: CALL 888-844-0080 and FAX completed / signed referral form to 336-718-9270**

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 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ DOB \_\_\_\_\_  
 Insurance(s): \_\_\_\_\_  
 (please fax copy of insurance information)

Language Spoken other than English  Spanish  Other

**Diabetes Diagnosis:**  
 Type 1  Type 2:  Controlled  Uncontrolled  
 Gestational (weeks gestation \_\_\_\_\_)  
 Pre-existing diabetes & pregnancy (weeks gestation \_\_\_\_\_)  
 Impaired Glucose Tolerance, Impaired Fasting Glucose, Metabolic Syndrome  
 Other \_\_\_\_\_

**Patient has special needs to receive individual instruction. (Check all that apply)**  
 Vision  Hearing  
 Physical  Cognitive  
 Language limitations  Other \_\_\_\_\_

**Most recent relevant lab results:** *We must have relevant lab results prior to meeting with your patient!*  
**Date** \_\_\_\_\_ **(Please fill in blanks or fax relevant labs)**  
 Cholesterol \_\_\_\_\_ Triglycerides \_\_\_\_\_ HgbA1c \_\_\_\_\_  
 HDL \_\_\_\_\_ B/P \_\_\_\_\_ Glucose \_\_\_\_\_  
 LDL \_\_\_\_\_ Other \_\_\_\_\_

**GTT results for GDM or if applicable**  
**Date** \_\_\_\_\_ **Fasting** \_\_\_\_\_ **1hr** \_\_\_\_\_ **2hr** \_\_\_\_\_ **3hr** \_\_\_\_\_

**Complications / Co-Morbidities (check all that apply):**  
 Cancer \_\_\_\_\_  Eating Disorders  Hypertension  Renal Failure (list restrictions) \_\_\_\_\_  
 Cardiovascular Disease  Food Allergies  Hypoglycemia  Retinopathy \_\_\_\_\_  
 Celiac  Foot problems  Nephropathy  Tube Feedings \_\_\_\_\_  
 CVD  Gastric Bypass Pre/Post  Neuropathy  Under Weight / Malnourished \_\_\_\_\_  
 Depression  Gastroparesis  Obesity: Pediatric / Adult  Other \_\_\_\_\_  
 Dyslipidemia  GI Disorders \_\_\_\_\_  Pregnancy

**Plan of Care / MD Orders**

<input type="checkbox"/> <b>Thomasville</b>  <b>*Diabetes Self Management Training (DSMT)</b> <input type="checkbox"/> Initial training (includes 1 hour assessment and 4 hr Basics class) <input type="checkbox"/> Gestational Diabetes/Diabetes and Pregnancy  <b>**Medical Nutrition Therapy (MNT)</b> <b>Diabetes Specific:</b> <input type="checkbox"/> Initial MNT <input type="checkbox"/> Additional MNT <input type="checkbox"/> Annual follow-up MNT - Specify change in Dx, medical condition, or treatment regiment: _____  <i>*Medicare allows 10 hrs. initial in 12 month period, plus 2 hrs follow up annually</i> <i>**Medicare allows 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually.</i> <i>Additional MNT hours available for change in medical condition, treatment and/or diagnosis.</i>	<input type="checkbox"/> <b>Kernersville</b>  <b>*Diabetes Self Management Training (DSMT)</b> <input type="checkbox"/> Initial training (includes 1 hour assessment and 4 hr Basics class)  <input type="checkbox"/> <b>Diabetes Prevention Class (Pre-DM, IGT, IFG)</b>
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**Desired Outcomes for DM Patients:**  
 HgbA1c \_\_\_\_\_  B/P \_\_\_\_\_  LDL \_\_\_\_\_

**Patient Behavioral Goals:** \_\_\_\_\_

**I hereby certify that I am managing this beneficiary's Diabetes condition/Medical Nutrition Therapy and that the above prescribed training is a necessary part of management> (Medicare patients)**

<b>MD Name (Please Print)</b>	<b>MD, DO, PA, NP Signature</b>	<b>Date/Time</b>
<b>Group Practice Name</b>	<b>(Phone)</b>	<b>(Fax)</b>