

PVMC Referral/Order for Diabetes Self-Management Training

Patient Name: (last) _____ (first) _____ M F DOB: _____

Patient phone: H _____ W _____ Cell _____

Primary language: Eng Span Other: _____ Print name of referring MD: _____

MD phone #: _____ MD fax #: _____

Please mark @ least 1 diagnosis/condition:

- New Onset Diabetes** **Type 1** **Type 2** (FBG \geq 126 on 2 occasions, or random BG \geq 200 w/ symptoms)
- Uncontrolled blood glucose (A1C >8)**
- Change in treatment regimen**
 - No DM meds to DM meds
 - Oral meds to insulin
- High risk for complications**
 - Poor glycemic control & acute episode hypo/hyperglycemia requiring ER treatment &/or hospitalization
- High risk based on**
 - Lack of feeling in foot/feet, or other foot complications (ulcer, amputation, etc.)
 - Pre-proliferative or proliferative retinopathy prior to laser eye treatment
 - DM-related kidney complications (macroalbuminuria or \uparrow creatinine)
- GDM**
- Pregnancy with pre-existing** **DM 1** **DM 2**

Other diagnoses: _____

Current medications: _____

Please mark @ least 1 desired treatment:

- DSMT/MNT that includes:**
 - Being active/physical activity
 - Eating plan
 - Use of oral medications/insulin
 - Monitoring diabetes
 - Problem-solving/goals-setting
 - Reducing risks of complications
 - Psychosocial adjustment to diabetes
 - Diabetes as disease process
- MNT (medical nutrition therapy) only**
- CDE or RN may adjust insulin & notify MD of changes**
- Gestational Diabetes Management**
- Pre-gestation DM Counseling**

Please mark 1 desired frequency/duration of treatment & document need for 1:1 education

- 1-2 individual sessions with 4 group classes & when possible, follow-up education in 6-12 mos.
 - 1:1 education only due to**
 - ___ GDM or PG with pre-existing DM ___ Language barrier
 - ___ 1:1 insulin instruction ___ 1:1 MNT or SMBG
 - ___ Severe vision, cognitive, hearing or physical limitations
- Other: _____

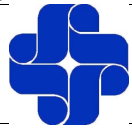
Healthcare Professional's Signature: _____

Date: _____

Please assure the following is included with this fax:

- Copy of **front and back** of patient's insurance card
- Recent pertinent labs Mark if labs are in PVMC Vertisoft system
- Recent office progress notes
- Healthcare provider signature
- All** appropriate sections above are marked

**Fax to PVMC Admitting Dept:
303.498.1515**



PVMC Referral/Order for Non-Diabetic Medical Nutrition Therapy And Pre-Diabetes Medical Nutrition Therapy

Patient Name: (Last) _____ (first) _____ M F DOB: _____

(For pediatric patients) Parent/Guardian name: _____

Patient/Guardian Phone: H _____ W _____ Cell _____

Primary Language: Eng. Span other: _____

Please print name of referring MD _____ MD Phone #: _____ Fax #: _____

Please mark @ least one diagnosis/condition:

Diagnosis	ICD9 Code
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- | | |
|---|-------|
| <input type="checkbox"/> Dyslipidemia | _____ |
| <input type="checkbox"/> IFG/IGT (Pre-diabetes)* | _____ |
| <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Obesity (BMI >30) | _____ |
| <input type="checkbox"/> Unintended weight loss/FTT | _____ |
| <input type="checkbox"/> Celiac Disease | _____ |
| <input type="checkbox"/> Renal Failure | _____ |
| <input type="checkbox"/> Renal Insufficiency | _____ |
| <input type="checkbox"/> Functional Hypoglycemia | _____ |
| <input type="checkbox"/> Other: _____ | _____ |

Patient's meds: _____

Other diagnoses: _____

Please note desired number of MNT sessions: _____

***Due to limited insurance coverage for pre-diabetes education, patients will be encouraged to attend PVMC pre-DM classes at a reasonable out-of-pocket cost.**

Please assure the following is included with this referral:

- Copy of *front and back* of patient's insurance card
- Recent pertinent labs
- Mark if labs are in PVMC Vertisoft system
- Pertinent office notes
- For pediatric patients: **NCHS Growth records**
- Healthcare professional's signature

*** Healthcare Professional's Signature:**

Date: _____

***Fax this referral to
303.498.1515 (admitting
department)***

**PVMC Wellness Education Dept.
303.498.1699
Thank-you for the referral.**