



DIABETES EDUCATION OUTPATIENT PHYSICIAN REFERRAL

Appointment Location: ___ Asheville ___ Marion Appointment Date & Time: _____ / _____

TO SCHEDULE APPT. IN ASHEVILLE (Check 1 Box ONLY):

- If *One Call Scheduling* needs to call patient for appointment, fax completed referral to **(828) 213-4877**.
- If MD's office wants to schedule appointment directly, call: *One Call Scheduling* at (828) 213-2222, Option #2.

Once appointment is scheduled, *One Call Scheduling* will fax the completed referral to: (828) 213-3333.

TO SCHEDULE APPOINTMENT IN MARION, NC:

- MD's office needs to fax completed referral to McDowell Hospital Diabetes Center at (828) 659-5439 (Fax). Someone from McDowell Hospital will call patient to schedule their appointment.

If you have questions and need to speak to someone directly, please call McDowell Hospital Diabetes Center at (828) 659-5157.

Patient's Name: _____ SSN: _____ DOB: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Health Insurance: _____

Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

DIAGNOSIS

(Please send recent labs for outcomes evaluation)

- Type 1 - Controlled Type 1 - Uncontrolled
- Type 2 - Controlled Type 2 - Uncontrolled
- Gestational Diabetes

Patient has special need(s) to receive individual instruction (Check all special needs that apply):

- Vision Hearing Physical
- Cognitive Impairment Language Limitations
- Other: _____

DIABETES SELF MANAGEMENT TRAINING (DSMT)

(Check type of education services being ordered)

- Diabetes Initial Training / Assessment**
- Diabetes Educational Classes**
- Gestational Diabetes Classes**
- Insulin Pump Training**

Other Training:

- New to Insulin / Injections (Incretins)
- Sick Days Glucagon Lifestyle Mgmt. Education
- Glucose Sensor (CGMS) & Education
- Other: _____

LABS

(Please list or attach copy of current results)

A₁C: _____ Date: _____ HDL: _____ Date: _____
LDL: _____ Date: _____ Triglycerides: _____ Date: _____

MEDICATIONS

Please list doses/frequency below current diabetes medications, and/or attach copy of current medicines and dosages)

Insulin:

Type/Dose _____ acB _____ acL _____ acS _____ acHS
Type/Dose _____ acB _____ acL _____ acS _____ acHS

Attach Correction / Supplemental Insulin Schedule.

Target Blood Glucose _____ Insulin Sensitivity Factor: _____

MEDICAL NUTRITION THERAPY (MNT)

(Check services being ordered)

Provided by a Registered Dietitian, Certified Diabetes Educator:

- Initial MNT** (Meal planning consult)
- Annual follow-up MNT**
- Additional MNT** services in the same calendar year, per RD recommendations (Please specify change in diagnosis, medical condition, or treatment regimen):



MD's Signature: _____ UPIN #: _____ Date: _____

Group / Practice Name: _____ Phone: (____) _____ Fax: _____