Legacy Diabetes and Nutrition Education

Physician Referral Form

LEGACY
H E A L T H

Please complete this form, print and sign, then fax to the appropriate location:

☐ **Good Samaritan**
Phone: 503-413-7227
Fax: 503-413-6888

☐ **Meridian Park***
Phone: 503-692-7791
Fax: 503-692-7788

☐ **Mount Hood***
Phone: 503-674-1254
Fax: 503-674-1267

☐ **Emanuel***
Phone: 503-413-4340
Fax: 503-413-4898

☐ **St. Helens**
Phone: 503-397-0471
Fax: 503-366-3014

☐ **Salmon Creek***
Phone: 360-487-2727
Fax: 360-487-4849

☐ **Silverton***
Phone: 971-983-5212
Fax: 503-944-6813

* A hospital based department

Patient information

Last name _____ First name _____ Middle initial _____

Date of birth _____ Home phone _____ Other phone _____ Insurance _____

Diabetes diagnosis *(please include ICD-10 code if not listed)*   **Date of diagnosis** _____

☐ Type 1 diabetes without complication – E10.9
☐ Type 1 diabetes with hyperglycemia – E10.65
☐ Type 2 diabetes without complication – E11.9

☐ Type 2 diabetes with hyperglycemia – E11.65
☐ Gestational Diabetes – O24.419
☐ Pre-existing DM in Pregnancy- O24.319

☐ Other: _____

Diabetes Self-Management Education and Support (DSMES).
If # of hours are not specified, DSMES team will defer to number of hours allowed per insurance benefit. Group classes include diabetes self-care skills, healthy eating, role of exercise and avoiding complications.

☐ **Comprehensive Diabetes Self-Management Training** (up to 10 hours for Medicare and/or 3 hours Medical Nutrition Therapy)

☐ **Diabetes Refresher- Type 1 or 2** (up to 2 hours for Medicare and/or 2 hours MNT) Focused self-care topics such as healthy eating, glucose monitoring, role of exercise and avoiding complications.

☐ **Gestational Diabetes**

☐ **Pre-Existing Diabetes in Pregnancy**

☐ **Continuous Glucose Monitoring Training and/or Interpretation.** Sensor start, download and interpretation.

☐ **Insulin Pump Training Management.** Includes assessment, pump start (if indicated), insulin adjustment and follow up.

Medication Orders
Educator may start or adjust insulin per protocol? ☐ Yes ☐ No

Educator may adjust other DM medications per protocol? ☐ Yes ☐ No

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Special Needs: Medicare will cover individual Diabetes Education only if one of the following is documented by the referring provider):

☐ Vision   ☐ Hearing   ☐ Language   ☐ Cognitive   ☐ Physical   ☐ Psychological   ☐ Transportation   ☐ Other: _____

Educational Needs:

☐ All content identified by CDCES

☐ Healthy coping
☐ Monitoring

☐ Taking Medication
☐ Healthy Eating

☐ Taking Medication
☐ Reducing Risk

☐ Being Active
☐ Problem Solving

☐ Other: _____

Medical Nutrition Therapy (MNT): evidence-based nutrition counseling for the treatment and prevention of disease.

☐ MNT

MNT Diagnosis Codes:

☐ Prediabetes- R73.03
☐ Overweight (BMI 25.9 – 29.9)- E66.3
☐ Obesity (BMI 30.0 – 39.9)- E66. 9
☐ Morbid Obesity (BMI >40.0)- E66.01

☐ Abnormal Weight Loss- R63.4
☐ Abnormal Weight Gain- R63.5
☐ Hyperlipidemia- E78.5
☐ Hypertriglyceridemia- E78.1

☐ Hypertension- 401.9
☐ Celiac Disease- K90.0
☐ CKD, stage 3- N18.3
☐ CKD, stage 4- N18.4

☐ CKD, stage 5- N18.5
☐ ESRD- N18.6
☐ Polycystic Ovarian Syndrome- E28.2

Please Include ICD-10 Code for the following:
Cancer: _____   GI Disorder(s): _____   Other: _____

➜ **Important! Please FAX recent progress notes, problem list, pertinent labs (A1c, Lipids, 3-HR GTT, other) and list of medications (required by The Joint Commission).** *(Not necessary if patient record is in Legacy EMR)*

Referring provider authorization

As the health care provider managing this patient's diabetes care, I certify that this training is needed to ensure therapy compliance and provide the necessary skills and knowledge to enable the patient to manage his/her condition.

Referring provider

Name _____ Clinic _____ Phone _____ Fax _____

Primary care provider (if different) _____ Clinic _____ Phone _____ Fax _____

Physician signature _____ Date _____