EXAMPLE

SHORT REFERRAL

Date: _____

Referring Provider and NPI: _____

Participant's Name: _____ DOB: _____

Phone#: _____

Diabetes Diagnosis:

☐Type 1 ☐ Type 2 ☐ Gestational
☐ Pre-Existing DM with Pregnancy ☐ Pre-diabetes

Referral For:

☐ Initial Comprehensive Diabetes Self-Management Training (DSMT) – 10 hrs. and all 9 topics (Diabetes disease process, Nutrition, Physical activity, BG monitoring, Medication, Acute complications, Chronic complications, Psychosocial concerns and Health/Behavior change)
☐ DSMT: Follow-up – 2 hrs.
☐ Medical Nutrition Therapy (MNT) Initial – 3 hrs.
☐ MNT: Follow up – 2 hrs.
☐ Specific Topics and Hours if needs vary from above:_____
*DSMT can be ordered by an MD, DO or midlevel provider managing the participant's diabetes.
**MNT must be ordered by MD or DO managing the participant's diabetes.

Indicate any barriers to group learning or additional insulin training requiring _____ hours of 1:1 training:

☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing ☐ Impaired dexterity

☐ Impaired mental status/cognition ☐ Language barrier

☐ Learning disability or other (please specify):_____

☐ 1:1 Insulin Training

I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management. (Medicare participants)

Physicians Signature: _____

Date: _____