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
☐ 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 can be ordered by any MD or DO.

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 ☐ Eating disorder
☐ 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)

Provider's Signature: _________________________________

Date: ____

Copyright © 2022 by American Diabetes Association All rights reserved.
This document or any portion thereof may not be reproduced or used in any manner whatsoever without the express written permission of the American Diabetes Association.