

EXAMPLE
SHORT REFERRAL

DSME Referral: _____ **Date:** _____

Patient's Name: _____ **DOB:** _____

Phone#: _____

Diabetes Diagnosis:

- Type 1, controlled Type 1, uncontrolled Type 2, controlled Type 2, uncontrolled
 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: _____

*DSME can be ordered by an MD, DO or midlevel provider managing the patient's diabetes.

**MNT must be ordered by MD or DO.

Indicate any barriers to group learning or additional insulin training requiring 1:1 education:

- 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

Physicians Signature: _____

Date: _____