



DIABETES HEALTH CENTER

A program of Community Health Trust

REFERRAL FOR DIABETES SELF-MANAGEMENT EDUCATION AND MEDICAL NUTRITION THERAPY

Name: _____ DOB: _____ Female: Male: Phone: _____

Insurance: Medicare MediCal Alliance Dignity Other: _____

Wt: _____ Ht: _____ BMI: _____ B/P: _____ Language: _____ PCP Name: _____

PLEASE FAX REFERRAL WITH COPY OF LAB RESULTS & LIST OF MEDICATIONS

STEP 1: PRIMARY DIAGNOSIS

Diabetes Self-Management Education (DSME) and/or Medical Nutrition Therapy (MNT):

Type 1 Type 2 Diabetes in Pregnancy (Please fax copy of prenatal records)

ICD-10 Diagnosis Code(s) (REQUIRED):

Medicare: 10 hours initial DSME in 12-month period plus 2 hours follow-up DSME annually:

Initial DSMT: 10 hours Additional insulin training _____ hours requested Follow-up DSMT: 2 hours

(AND)

Medicare: 3 hours initial MNT in the first calendar year, plus 2 hours follow-up annually:

Initial MNT: 3 hours Annual Follow-up: 2 hours
 Additional MNT services in the same calendar year, per RD recommendations No. of Hours _____

Non-Diabetes Medical Nutrition Therapy:

Diagnosis Code(s): _____

STEP 2: ADDITIONAL COMPLICATIONS AND CO-MORBIDITIES (check all that apply)

Hypertension Dyslipidemia Stroke PCOS Non-healing wound
 Neuropathy Nephropathy CVD Retinopathy Mental/affective disorder
 Obesity Metabolic Syn. PVD Other _____

STEP 3: PATIENTS WITH SPECIAL NEEDS REQUIRING INDIVIDUAL DSME OR MNT

Vision Hearing Physical Cognitive Impairment Language limitations Other _____

LABS (for all diagnoses):

FBG: _____ OR 1° GTT: _____ 2° GTT: _____ 3° GTT: _____ OR Random BG: _____
GFR: _____ A1c: _____ Trig: _____ Chol: _____ LDL: _____ HDL: _____ Micro albumin: _____
S Creatinine: _____ Other: _____

Patient Behavior Goals / Plan of Care:

PCP Signature: _____

Date: _____

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Diabetes Health Center of the Community Health Trust of Pajaro Valley

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