Iowadiabetes Referral Form

Provider Information

First Name: _____ **Last Name:** _____

Phone: _____ **Fax:** _____

Group/Practice Name: _____

Patient Information

First Name: _____ **Last Name:** _____

Phone: _____ **Email:** _____

Date of Birth: _____/_____/_____ **Gender:** ☐ Male ☐ Female

Insurance: ☐ Medicare ☐ United Health Care ☐ Medicaid ☐ BCBS ☐ Other _____

Diabetes History

Diagnosis: ☐ Type 1 with Hyperglycemia (E10.65) ☐ Type 1 with Hypoglycemia (E10.64)

☐ Type 2 with Hyperglycemia (E11.65) ☐ Type 2 with Hypoglycemia (E11.64)

Year of Diagnosis: _____ **Most Recent A1c (%):** _____ **Date Done:** _____/_____/_____

Referring patient for (*may choose more than one*)

☐ Research ☐ Specialized Care ☐ Diabetes Self Management Education Support & Training (DSMES/T) ☐ Medical Nutrition Therapy (MNT)

If referring for DSMES/T, specify the content you want covered:

☐ All content ☐ Acute complications ☐ Goal setting ☐ Problem solving

☐ Monitoring diabetes ☐ Psychological adjustment ☐ Medications ☐ Chronic complications

☐ Nutritional management ☐ Diabetes as disease process ☐ Physical activity

If referring for DSMES/T or MNT, select the type of service and number of hours:

☐ Initial DSMES/T session (10 hours) ☐ Initial MNT session (3 hours)

☐ Follow-up DSMES/T session (2 hours) ☐ Follow-up MNT session (2 hours)

Additional MNT hours require a change in: ☐ Medical condition ☐ Treatment ☐ Diagnosis Hours desired _____

Comments: _____

_____

_____ _____

Physician Signature **NPI #**

Please fax medical history, medication list, and last lab results to us at 515-329-6799