PATIENT HAS THE FOLLOWING:

❑ **Type 2** ❑ **Prediabetes** ❑ Other:_____

❑ **Type 1** ❑ **Gestational diabetes** _____

❑ No complications _____

❑ Complications: Please specify:

Microvascular
- ❑ Retinopathy
- ❑ Neuropathy
- ❑ Nephropathy

Vascular Risks Co−Morbidities
- ❑ HTN
- ❑ Tobacco use
- ❑ Hyperlipidemia

REASON FOR REFERRAL:

❑ New diagnosis ❑ Uncontrolled diabetes (A1c>8)

❑ Change in treatment ❑ Frequent hypoglycemia

Please note that Medicare patients can receive both DSMT and MNT.

SERVICE(S) REQUESTED (Please check all that apply):

- ❑ Diabetes Self−Management Training (Indicate if individual or group)
  - ❑ Individual
  - ❑ Group (4−part, comprehensive course)
- ❑ Medical Nutrition Therapy
- ❑ Meter Instruction and Training
- ❑ Insulin Start (Type/Dose) _____
- ❑ Byetta/Symlin Start/Training: _____
- ❑ Continuous Glucose Monitoring Sensor (CGMS) (A 72 hour blood glucose monitoring device)
- ❑ Insulin Pump Training

INSTRUCTIONS FOR THE EDUCATOR:

- ❑ **Diabetes Educator to Adjust Insulin per Insulin Adjustment Protocol**
- ❑ Specific diet instructions:_____
- ❑ RD to determine carbohydrate
- ❑ Please check A1C during visit

PLEASE INDICATE ANY LEARNING BARRIERS

- ❑ Vision
- ❑ Hearing
- ❑ Physical Handicap
- ❑ Language
- ❑ Learning Disability
- ❑ Mental Handicap

PLEASE LIST CURRENT DIABETES MEDICATIONS

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE FAX RECENT LABS AND H&P

Fasting glucose:	**Date:**	**Random glucose:**	**Date:**
A1C:	**Date:**	**GTT (2 hour glucose test):**	**Date:**

_____ _____

Physician or Provider Signature Date / Time

Certificate of Medical Necessity for Diabetes Self−Management Training

Insurance: _____ # visits auth'd:_____ Authorization #:_____

Wentworth−Douglass Hospital

DIABETES SERVICES

REFERRAL FORM: DIABETES EDUCATION

DD0060

7130−11MR

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