Ascension Sacred Heart

Diabetes & Nutrition Referral

Pensacola, Destin & Port St Joe
Fax referral to: 850-416-7246
Phone: 850-416-7262

PATIENT INFORMATION-PLEASE PRINT

First Name: **Last Name:** **MI:**

DOB: ____/____/____ **Gender:** **Male** **Female**

Address: **City:** **State:** **Zip Code:**

Home Phone: **Cell Phone:** **Other:**

Insurance: **Policy Holder's Name:**

ID#: **Group #:** **Ins Phone #:**

DIAGNOSIS (Please include DX Code)

Type 1-uncontrolled (E10.65) Type 1-controlled (E10.9) Pre-Diabetes (R73.03)
Type 2-uncontrolled (E11.65) Type 2-controlled (E11.9) Impaired Fasting Glucose IFG (R73.01)
Gestational Diabetes (024.419) Other: _____

ATTACH THE MOST RECENT H&P & RECENT LABS: (A1C, LIPID PANEL, MICROALBUMIN, ETC.)

Diabetes Self-Management Education/Training (DSME/T) ***Can be ordered by an MD, DO or midlevel provider managing patient's diabetes.***

Group DSME/T: 10 hours-Initial Class
Annual Follow-up: 2 hours-*Patient already received 10 hr training*
Group Class: GDM and T2DM and Pregnant
Individual DSME/T
Nutrition Education
Medication Education/Instruction: _____
Pump Education: _____
Type 1 Diabetes & Pregnant
Continuous Glucose Monitoring (CGM)
Professional
Personal: _____

Check special needs requiring your patient to have a 1-1 appointment when class not appropriate.

☐ Vision, Hearing, Physical, Cognitive or Language Limitations
☐ Patient needs additional instruction on medication use
☐ Other (please specify): _____

Medical Nutrition Therapy (MNT) ***Must be ordered by MD or DO.***

Medicare covers 3 hours initial in the 1st calendar year for persons with diabetes or kidney dz, plus 2 hours each year thereafter. Additional MNT hrs available if patient has a change in medical condition, treatment and/or diagnosis.

MNT (CPT Codes: 97802, 97803)

Diet order: _____

REFERRING PROVIDER INFORMATION

Provider Name (PLEASE PRINT): **NPI:**

Office Contact: **Office Phone #:** **Office Fax #:**

I hereby certify that I am managing this patient's diabetes diagnosis and this order is an integral part of my comprehensive care.

Provider Signature: **Date:**