

Diabetes Service Order Form (DSMT and MNT Service)

Please fax the referral form to the Brunswick County's Diabetes Program at 910.253.2370

Highlighted fields indicate required information

Patient Information:

Patients Name _____ SS# _____
DOB _____
Contact number _____ Health Insurance _____

Diabetes Diagnosis:

- Type 1, Controlled (250.01) Type 1, Uncontrolled(250.03)
 Type 2, Controlled(250.00) Type 2, Uncontrolled(250.02)
 Gestational(648.8) Pre-existing DM with pregnancy (648.0) Pre-diabetes (790.29)

Current Treatments:

- Diet and Exercise Oral Agents: _____
 Insulin: _____

Indicate one or more reasons for referral:

- Newly diagnosed
 Recurrent elevated blood glucose levels
 Recurrent Hypoglycemia
 Change in DM treatment regimen
 High risk due to diabetes complication/Co-morbid conditions:
 Retinopathy Neuropathy Gastroparesis Hyperlipidemia
 Hypertension Cardiovascular disease Other: _____

Recent Labs: Please fax most recent labs with referral

Education Needed:

- Comprehensive Self Management Skills (group)
 Comprehensive Self Management Skills (individual sessions)
 Insulin Instruction
 Basic Nutrition Management
 Medical Nutrition Therapy (MNT)
 Self Blood glucose monitoring
 Management of diabetes during pregnancy/Gestational Diabetes Education
 Insulin Pump Instruction

Indicate any existing barriers requiring customized education:

- Impaired mobility Impaired Vision Impaired Hearing
 Language barrier
 Learning disability (please specify) _____
 Other _____

Medicare Patients:

I hereby certify that I am managing this beneficiary's diabetes condition and that the above prescribed training is a necessary part of management.

Physician's Signature (Required) _____ NPI# _____

Physician's Name (Printed) _____

Name of Practice (Printed) _____ Phone # _____

Date _____

Diabetes Service Order Form (DSMT and MNT Service)

Please fax the referral form to the Brunswick County's Diabetes Program at 910.253.2370

Highlighted fields indicate required information

Physician's Signature (Required) _____ NPI# _____

Physician's Name (Printed) _____

Name of Practice (Printed) _____ Phone # _____

Date _____