DIABETES EDUCATION
OUTPATIENT PHYSICIAN REFERRAL

Appointment Location: ___ Asheville ___ Marion **Appointment Date & Time: ___________/ ___________**

TO SCHEDULE APPT. IN ASHEVILLE (*Check 1 Box ONLY*):	TO SCHEDULE APPOINTMENT IN MARION, NC:
☐ If *One Call Scheduling* needs to call patient for appointment, fax completed referral to **(828) 213-4877**. ☐ If MD's office wants to schedule appointment directly, call: *One Call Scheduling* at (828) 213-2222, Option #2. **Once appointment is scheduled, *One Call Scheduling* will fax the completed referral to: (828) 213-3333.**	☐ MD's office needs to fax completed referral to McDowell Hospital Diabetes Center at (828) 659-5439 (Fax). Someone from McDowell Hospital will call patient to schedule their appointment. If you have questions and need to speak to someone directly, please call McDowell Hospital Diabetes Center at (828) 659-5157.

Patient's Name: ______________________ SSN: ______________ DOB: ____________

Home Phone: (   ) ______________ Cell Phone: (   ) ______________ Health Insurance: ______________

Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

DIAGNOSIS

(Please send recent labs for outcomes evaluation)

- ☐ Type 1 - Controlled
- ☐ Type 1 - Uncontrolled
- ☐ Type 2 - Controlled
- ☐ Type 2 - Uncontrolled
- ☐ Gestational Diabetes

Patient has special need(s) to receive individual instruction (Check all special needs that apply):

__ Vision __ Hearing __ Physical
__ Cognitive Impairment __ Language Limitations
__ Other: ______________________________________

DIABETES SELF MANAGEMENT TRAINING (DSMT)

(Check type of education services being ordered)

- ☐ **Diabetes Initial Training / Assessment**
- ☐ **Diabetes Educational Classes**
- ☐ **Gestational Diabetes Classes**
- ☐ **Insulin Pump Training**

Other Training:

__ New to Insulin / Injections (Incretins)
__ Sick Days __ Glucagon __ Lifestyle Mgmt. Education
__ Glucose Sensor (CGMS) & Education
__ Other: ______________________________________

LABS

(Please list or attach copy of current results)

A_1C: _______ Date: _______ HDL: ________ Date: ________
LDL: _______ Date: _______ Triglycerides: _____ Date: _____

MEDICATIONS

Please list doses/frequency below current diabetes medications, and/or attach copy of current medicines and dosages)

____

____

Insulin:

Type/Dose _____ acB _____ acL _____ acS _____ acHS

Type/Dose _____ acB _____ acL _____ acS _____ acHS

Attach Correction / Supplemental Insulin Schedule.
Target Blood Glucose _____ Insulin Sensitivity Factor: _____

MEDICAL NUTRITION THERAPY (MNT)

(Check services being ordered)
Provided by a Registered Dietitian, Certified Diabetes Educator:

- ☐ **Initial MNT** (Meal planning consult)
- ☐ **Annual follow-up MNT**
- ☐ **Additional MNT** services in the same calendar year, per RD recommendations (Please specify change in diagnosis, medical condition, or treatment regimen):

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Patient Label Goes Here

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MD's Signature: ______________________ UPIN #: ______________ Date: ____________

Group / Practice Name: ______________________ Phone: (   ) ______________ Fax: ____________