EXAMPLE

SHORT REFERRAL

Date: _____

Referring Provider and NPI: _____

Participant's Name: _____ DOB: _____

Phone#: _____

Diabetes Diagnosis:

☐Type 1 ☐ Type 2 ☐ Gestational
☐ Pre-Existing DM with Pregnancy ☐ Pre-diabetes

Referral For:

☐ Initial Comprehensive Diabetes Self-Management Training (DSMT) – 10 hrs. and all 9 topics
☐ DSMT: Follow-up – 2 hrs.
☐ Medical Nutrition Therapy (MNT) Initial – 3 hrs.
☐ MNT: Follow up – 2 hrs.
☐ Specific Topics and Hours if needs vary from above:_____
*DSMT can be ordered by an MD, DO or midlevel provider managing the participant's diabetes.
**MNT can be ordered by any MD or DO.

Indicate any barriers to group learning or additional insulin training requiring _____ hours of 1:1 training:

☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing ☐ Impaired dexterity
☐ Impaired mental status/cognition ☐ Language barrier ☐ Eating disorder
☐ Learning disability or other (please specify):_____
☐ 1:1 Insulin Training
☐ 1:1 Due to COVID-19 Public Health Emergency allowance

I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management. (Medicare participants)

Provider's Signature: _____

Date: _____