THE NATIONAL DIABETES & OBESITY RESEARCH INSTITUTE AT TRADITION

The National Diabetes and Obesity Research Institute

DSME/T, MNT and Program Services Referral Form

Patient's Last Name:	First Name:	Middle:	Gender: ☐ Male ☐ Female	DOB: _____/_____/_____
Address:		City:	State:	Zip:
Home Phone:	Mobile Phone:		Email Address:	

Diagnosis

☐ Type 1 ☐ Type 2
☐ Gestational ☐ Pre-Diabetes
☐ Obesity

ICD-10 Diagnosis code:_____

Complications/Comorbidities

Check all that apply:

☐ Hypertension ☐ Dyslipidemia ☐ Stroke
☐ Neuropathy ☐ PVD ☐ CHD
☐ Kidney Disease ☐ Retinopathy ☐ Pregnancy
☐ Non-healing wound ☐ Mental/affective disorder ☐ Other: _____

ICD-10 Diagnosis code _____

Diabetes Self-Management Education/Training (DSME/T)

Check Type of training services and number of hours requested:

☐ Initial group DSME/T: ☐ 10 hours or ____ no. hrs. requested
☐ Follow-up group DSME/T: ☐ 2 hours or ____ no. hrs. requested

DSME/T Content: ***Only select below if referring for Follow-Up***

☐ Monitoring diabetes ☐ Diabetes as disease process
☐ Psychological adjustment ☐ Physical Activity
☐ Nutritional management ☐ Goal setting, problem solving
☐ Medications ☐ Prevent, detect and treat acute complications
☐ Preconception/pregnancy management or GDM ☐ Prevent, detect and treat chronic complications

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply:

☐ Vision ☐ Hearing
☐ Cognitive Impairment ☐ Physical
☐ Additional training ☐ Language limitations
☐ additional hrs requested _____ Other: _____

Medical Nutrition Therapy (MNT)

Check the type of MNT and/or number of additional hours requested:

☐ Initial MNT ☐ 3 hours or ____ no. hrs. requested
☐ Annual follow up MNT ☐ 2 hours or ____ no. hrs. requested
☐ Additional MNT services in the same calendar year, per RD
Additional hrs. requested _____

Please specify change in medical condition, treatment and/or diagnosis:

_____

_____

_____

_____

Other Programs for Referral

☐ Diabetes Prevention Program (DPP)

☐ Medical Weight Management

Current Diabetes Medications *Write (or) Fax copy w/referral*

Oral: _____ Insulin: _____

Please fax copy of most recent labs to 228-233-1252

Additional Comments: _____

_____

_____

_____

_____

Signature and NPI # _____ Date _____/_____/_____

Group/Practice name: _____

Address: _____ Phone: _____

If there are any questions regarding this form, please call 228-831-8764.