PATH OF LIFE NUTRITION
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DIABETES EDUCATION (DSME/T) REFERRAL FORM

REQUIRED PATIENT INFORMATION

Name: _____ | DOB: _____ | Gender: _____

IF MINOR: Parent/Guardian Name: _____ | Relationship to Patient _____

Home Address: _____

Phone: _____ (HOME/CELL) | Email: _____

Insurance: _____| Prior Authorization #: _____

REFERRAL INFORMATION

DIABETES DIAGNOSIS:	ICD-10	COMORBIDITIES/COMPLICATIONS	
__Type I Diabetes	E10.9	__Chronic Kidney Disease	__Non-Healing Wound
__Type II Diabetes	E11.9	__Hypertension	__Coronary Heart Disease
__Gestational Diabetes	O24.419	__Neuropathy	__Retinopathy
__Pre-existing Type 1 DM in pregnancy	O24.019	__Peripheral Vascular Disease	__Stroke (CVA)
__Pre-existing Type 2 DM in pregnancy	O24.119	__Obesity/Morbid Obesity	__Dyslipidemia
__Pre-Diabetes	R73.03	__Pregnancy	__Mental/Affective Dx

DIABETES EDUCATION/COUNSELING/TRAINING SERVICES: *(NOTE: DSME/T & MNT are complementary therapies for improving diabetes management and research indicates IMPROVED outcomes when services combined together)*

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

__Initial Diabetes Self-Management Training (10 hrs)
__Annual DSMT Update Training (2 hrs)
__1:1 Additional Insulin Training
__Insulin Pump Assessment/Start-up Evaluation
__Insulin Pump w/Sensor Training
__Continuous Glucose Monitor Training

Medical Nutrition Therapy (MNT)

__Initial (MNT): __3 hrs | OR ___(# hrs)
__Annual Follow-up MNT: __2 hrs | OR ___(# hrs)
__Additional hrs of MNT services in same calendar year, per RD: ___**(# additional hours requested)**
Specify Change in Dx/Tx/Condition: _____
_____

Special needs requiring individual (1:1) DSME/T services (check all that apply):
__Vision | __Hearing | __Physical | __Cognitive Impairment | __Language Limitations | __Additional Training (___#hrs requested)

DSME/T Content:
__Prevent/treat/detect complications | __Monitoring Diabetes | __Diabetes as Disease Process | __Physical Activity | __Medication
__Nutritional Management | __Psychological Adjustment | __Goal Setting, Problem Solving | __Gestational Diabetes/Pregnancy

☐ **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 patients)**

Referring Physician Signature Required: _____

Referring Physician Print (REQUIRED): _____| Date: _____

Please fax REFERRAL, LABS & pertinent MEDICAL RECORDS to 803-728-3224 | Call 803-768-7179 for questions/appointments