MYDIABETESTUTOR

REFERRAL FORM

FAX 844.306.5999

Thank you for the referral to My Diabetes Tutor. Please fax this completed form to **844-306-5999, along with a copy of insurance cards, demographics, recent A1C, supporting labs, and progress notes necessary for services.**

PART I PATIENT INFORMATION

Full Name	Date of Birth	Gender: **Male** **Female** **Unknown** Other

Phone Number	Patient Email Address

Primary Language	Check the appropiate box for Diabetes Type: **Type 1** **Type 2** **Prediabetes** **Gestational** **Pre-existing Diabetes in Pregnancy**

MNT Diagnosis	ICD10 Code

A1C results within 3 months of referral (%)	Date	Preferred lab

Insurance Name	Preferred Pharmacy	Pharmacy Phone

Provider Name	Phone	Fax

Provider Practice Name	Next Provider Visit

Check the appropiate box where you referred from

Adventist Health **Alignment Health** **Kaweah Health** **Tricare** **United Health Centers** **Other**

PART II DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT (DSMES)

Check type of education /training services and number of hours requested

Initial DSMES 10 or hours (new diagnosis, no prior diabetes education).
Includes providing DSMES on nine standard topic areas based on pt. needs and reporting back to the referring provider.
Annual follow-up DSMES 2 hours (health maintenance & prevention of complications, new factors influencing self-care)
Device training requiring 1:1 visits (circle one): Insulin pump or CGM training
Additional DSMES for change in medical condition or treatment

List visit type

Individual. Check reason(s) why **no groups available within 2 months of referral** **virtual / distance to program**
Group **language barrier** **vision** **hearing** **mobility** **cognition**

PART III MEDICAL NUTRITION THERAPY (MNT)*

Check the appropiate box for Medical Nutrition Therapy **Initial MNT 3 hour** **Additional MNT hours for change in medical condition/diagnosis:** **Annual follow-up MNT 2 hours**	*Required: List number of MNT visits authorized:

PART IV REMOTE PATIENT MONITORING (RPM)

(Please check) I verify patient agrees and provides consent to verify insurance	Number of Educational/RPM Visits Authorized	Expiration Date:

I affirm managing this patient's medical condition and that the above referral is a necessary part of their management.

Provider NPI#	Provider Signature	Date

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