Referral Form

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, and other supporting labs and notes necessary for services.**

Patient Information:

Name:_____ **Date of Birth:**_____

Cell phone:_____ **Patient mail:** _____

Primary language: _____ **Gender: Male Female Unknown Other:**_____

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:**_____

Referred from: (circle one) Adventist Health Alignment Health Aria Health Center Dignity Health

Tricare United Health Centers Other:_____

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 _X_ no groups available within 2 months of referral ___virtual / distance to program
___language barrier ___vision ___ hearing ___mobility ___cognition

__ Group

Medical Nutrition Therapy (MNT)*

__ 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**:_____

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:** _____

CALL 559.530.3396
TEXT 559.212.4809
FAX 844.306.5999

880 W. 7th Street Suite 103
Hanford, CA 93230

mydiabetestutor.com