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, and other supporting labs and notes necessary for services.

PART I PATIENT INFORMATION

Full Name	Date of Birth	Gender Other
		☐ Male ☐ Female ☐ Unknown

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 Other

☐ Adventist Health ☐ Alignment Health ☐ Aria Health Center ☐ Dignity Health ☐ Tricare United Health Centers

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	*Required: List number of MNT visits authorized:
☐ **Initial MNT 3 hour** ☐ **Additional MNT hours for change in medical condition/diagnosis:** ☐ **Annual follow-up MNT 2 hours**	

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