MYDIABETESTUTOR

FAX REFERRAL FORM

***Fax completed form to:* 844.306.5999**

Thank you for referring to MDT. To complete: A) select a diagnosis, B) check at least one order box (Option 1, 2, or 3), and C) sign at bottom. You may fill out fields on screen, then print and sign—or print, fill out by hand, and sign. Attach insurance cards and any supporting documents if available. Once signed, fax to 844-306-5999.

PATIENT INFORMATION

LAST Name, First	Date of Birth	Gender ☐ Male ☐ Female ☐ Unknown or other	Primary Language

Phone Number	Home Address / City, State / Zip Code	Patient's Email

A)

Diabetes Dx

Type 2 Diabetes (T2D)	Type 1 Diabetes (T1D)	Diabetes in Pregnancy	
☐ T2D, no complications (E11.9)	☐ T1D, no complications (E10.9)	☐ Gestational (O24.419)	☐ Prediabetes (R73.03)
☐ T2D w/ hyperglycemia (E11.65)	☐ T1D w/ hyperglycemia (E10.65)	☐ Pre-existing T1D in Preg. (O24.03)	☐ Other diabetes (specify below in 'Other diagnosis')
☐ T2D w/ complications (E11.69)	☐ T1D w/ complications (E10.69)	☐ Pre-existing T2D in Preg. (O24.13)	

MNT Dx

☐ Hyperlipid. (E78.59) ☐ HTN (I10) ☐ Overweight (E66.3) ☐ Obesity unspec. (E66.9) ☐ Hypothyroid (E03.9) ☐ CKD stage 3 (N18.30) ☐ ESRD (N18.6)
☐ Other MNT diagnosis (specify below in 'Other diagnosis')

Other diagnosis not listed above (plus ICD10): _____

Reason for 1:1 visit: ☒ **distance** ☐ **language** ☐ **mobility** ☐ **cognition** ☐ **vision** ☐ **hearing**

A1C% (within 3 months of referral)	A1C Date	LAB Preferred

Provider Name	Phone	Fax

INSURANCE Name / Policy #

OPTION 1 DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT (DSMES)

Check education / training needed:

B)

Standard Orders (select one)

☐ **DSMES – Initial (standard 10 hours)**
New dx or no prior diabetes educ. Covers 9 core topics, tailored to pt., with provider updates.

☐ **DSMES – Annual (2 hours)**
Maintenance, prevent complications, new self-care factors.

☐ **DSMES – Additional**
Change in condition or treatment.

☐ **CGM Device Training**

Optional, Specific Orders

☐ **DSMES – Initial (less than standard 10 hours)**
Specify hours: _____

☐ **Insulin Pump Start and Training**

☐ **Insulin Pump Ongoing Training:** CDCES CPT may adjust Target Glucose, Correct Above, Insulin Duration, ISF, I:C ratio, and basal rate

☐ **Insulin Education, plus DSMES Initial 10 hours**
Per provider's orders, educate on insulin dose adjustment.
Adjust either injectable long-acting or short-acting insulin per visit—but not both:
Basal (long-acting): 1 unit daily until fasting 80–130 mg/dL
Bolus (short-acting): May adjust bolus or I:C ratio up to 20%
Other:_____

☐ **Other orders:**

OPTION 2 MEDICAL NUTRITION THERAPY (MNT)

Approve the following number of hours as authorized by insurance:

☐ **Initial MNT 3 hours** ☐ **Annual follow-up MNT 2 hours** ☐ **Additional MNT hours for change in medical condition / diagnosis**

OPTION 3 REMOTE PATIENT MONITORING (RPM), CHRONIC CARE MANAGEMENT (CCM), ENDOCRINOLOGY CONSULT

Check service type needed:

☐ **RPM: I verify patient provides consent to verify insurance and I approve number of hours authorized.**
☐ **CCM: I verify patient provides consent to verify insurance and I approve number of hours authorized.**
☐ **Endocrinology provider consult.**

I affirm that this provider manages the patient's condition and that this referral is necessary for their care.

Provider NPI#	C) Provider Authorized Signature REQUIRED for Services	Date
	X	