

Order Form for the Diabetes and Nutrition Center at Northwest Hospital

Thank you for referring your patient to the Diabetes and Nutrition Center at Northwest Hospital. This form is needed to order Diabetes Self-Management Education and/or Medical Nutrition Therapy for patients **with diabetes**.

Directions:

1. The provider overseeing their care must sign and date.
2. Please send recent labs and physician notes for the most comprehensive consult.
3. Completed forms/labs/notes may be faxed to 410-469-5835

Date: _____ Referring Provider: _____ NPI: _____

Address: _____ Phone: _____ Fax: _____

Participant's Demographics:

Participant's Name: _____ DOB: _____

Phone # _____ Address: _____

Diabetes Diagnosis & Referral: ICD-10 Code: _____

Type 1 LADA Type 2 Gestational Pre-existing DM with Pregnancy

Diabetes Referral for: (Please check DSMT and MNT for initial referrals)

Initial Comprehensive Diabetes Self-Management Training (DSMT)- 10 hours and all 9 topics

DSMT: Follow-up- 2 hours

Medical Nutrition Therapy (MNT) Initial- 3 hours

MNT follow-up – 2 hours _____ Additional MNT hours requested due to: _____

Telehealth

Specific topics and hours if needs vary above: _____

Indicate any barriers to group learning or additional insulin training requiring hours of 1:1 training:

Impaired mobility Impaired vision Impaired hearing Impaired dexterity Impaired mental status/cognition

Eating disorder Learning disorder or other (please specify): _____

Prescriber's signature and Date Required

I hereby certify that I am managing this beneficiary's diabetes or other stated condition and that the above prescribed training is a necessary part of management:

Prescriber: _____ **Date:** _____

Prescriber signature: _____ **Date:** _____