Diabetes Self-Management Training Program Options

Please fax this referral, authorization and recent labs to ***303-779-0956***

Patient Information:

Name_____ **DOB** _____**Telephone** #_____

Address _____City_____State _____Zip_____

Choose Diagnosis

o **Individualized Counseling/Group Counseling -** Procedure codes G0108 & G0109

DIABETES TYPE 2	DIABETES TYPE 1	TUNE UP	GESTATIONAL DIABETES
o E11.8 **T2DM** with unspecified complications o E11.9 **T2DM** without complications o E11._____ o New Diagnosis o Established Diagnosis o R73.09 **Pre-Diabetes** impairment of carbohydrate metabolism in which the criteria for diabetes mellitus are not all satisfied; called also impaired glucose tolerance and impaired fasting glucose, **HbA1C 5.7 to 6.4** not on medication.	o E10.8 **T1DM** with unspecified complications o E10.9 **T1DM** without complications o E10._____ o New Diagnosis o Established Diagnosis	o This is an individual follow-up appointment for those who have met with a registered dietitian or who have received diabetes self management training in the past. Please list ICD10:_____ Pump Start: Please list rates Basal_____ Bolus_____ CF_____	o O24.410 **GDM, diet controlled** o O24.414 **GDM, insulin controlled** This is an individual appointment for those who have been diagnosed with gestational diabetes. Appointments are made as a priority and will be monitored closely while communicating with providers regarding plan of care. Please list additional ICD10, if needed: _____
Please indicate most recent lab results (A1c):			

Notes/Comments**:** _____

_____

Diabetes Medications: (Specify type, dose, and frequency):

By Mouth/Oral:	Insulin start (specify dose/type) Basal: _____ Bolus _____ Insulin Dose Adjustment (specify dose/type) Basal: _____ Bolus _____

Complications/Co morbidities: (Please check all that apply)

Hypertension	o Mental/Affective Disorder	o Retinopathy	Other:
o Dyslipidemia	o PVD	o Stroke	_____
o CHD	o Renal Disease	o Nephropathy	_____
o Obesity	o Non Healing Wound	o Pregnancy	

Diabetes Self Management Training Special Needs: (Please check all that apply)

o Vision	o Hearing	o Physical
o Language Limitations	o Cognitive impairment	o Other:_____

Clients can call 303-320-2490 for scheduling, confirmations, or questions.

Find us at the Rose Medical Center, 4567 E 9th Ave, Denver, CO 80220, Ground Floor by Physical Medicine

Referred By (Print) _____ Date_____

Referrer's Signature and NPI _____Contact Number_____

We greatly appreciate your referral!

Health ONE® Rose Medical Center