

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

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

DIABETES TYPE 2	DIABETES TYPE 1	TUNE UP	GESTATIONAL DIABETES
<input type="radio"/> E11.8 T2DM with unspecified complications <input type="radio"/> E11.9 T2DM without complications <input type="radio"/> E11. _____ <input type="radio"/> New Diagnosis <input type="radio"/> Established Diagnosis <input type="radio"/> 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.	<input type="radio"/> E10.8 T1DM with unspecified complications <input type="radio"/> E10.9 T1DM without complications <input type="radio"/> E10. _____ <input type="radio"/> New Diagnosis <input type="radio"/> Established Diagnosis	<input type="radio"/> 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 _____	<input type="radio"/> O24.410 GDM, diet controlled <input type="radio"/> O24.414 GDM, insulin controlled This is an individual appointment for those who have been diagnosed with gestational diabetes. Appointments are made as a <u>priority</u> 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 _____
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Complications/Co morbidities: (Please check all that apply)

Hypertension <input type="radio"/> Dyslipidemia <input type="radio"/> CHD <input type="radio"/> Obesity	<input type="radio"/> Mental/Affective Disorder <input type="radio"/> PVD <input type="radio"/> Renal Disease <input type="radio"/> Non Healing Wound	<input type="radio"/> Retinopathy <input type="radio"/> Stroke <input type="radio"/> Nephropathy <input type="radio"/> Pregnancy	Other: _____ _____
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Diabetes Self Management Training Special Needs: (Please check all that apply)

<input type="radio"/> Vision <input type="radio"/> Language Limitations	<input type="radio"/> Hearing <input type="radio"/> Cognitive impairment	<input type="radio"/> Physical <input type="radio"/> Other: _____
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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!

