Diabetes Dayton
An agency of LifeCare Alliance

Referral for Diabetes Medical Nutrition Therapy

Providers and Office Staff: Please complete form and fax to 937-224-0240. Thank You!

Patient Information:

Name:_____ M___ F___ Birthdate:_____

Address:_____ City:_____ ZIP:_____

Phone Day:_____ Phone Eve:_____

Diabetes Diagnosis: ICD-10 Code Required: _____**

_____Type 1 DM with complications _____Type 1 DM without complications

_____Type 2 DM with complications _____Type 2 DM without complications

_____ Pre-diabetes _____Gestational Diabetes

_____Type 2 diabetes w/hyperglycemia _____Other

Co-morbidities *(please check all that apply)*:

___Hypertension ___Dyslipidemia ___Stroke ___Neuropathy ___PVD ___CHF

___Renal Disease ___Retinopathy ___Non-healing wound ___Mental/affective disorder

___Obesity ___Other_____

Current diabetes medication(s) *(please specify type and dosage)*:

Oral_____

Insulin_____

Patient now uses: ___pen ___syringe ___pump

Please provide the following, if available, for outcome monitoring:

HbA1c_____ Date:_____ Height _____ Weight _____ FBS_____ Date_____ BP_____/_____ Date_____

Most recent dilated eye exam: _____ Most recent foot exam: _____

Diabetes Self-Management Education:

___ all 9 areas as appropriate or:

___Monitoring glucose ___Diabetes as disease process

___Psychological adjustment ___Goal setting, problem solving

___Nutrition management ___Prevent, detect & treat *acute* complications

___Medications ___ Prevent, detect & treat *chronic* complications

___Physical activity (restrictions: _____)

Physician signature: _____ Date: _____

Printed name: _____ Office Name: _____

Phone Number: _____ Fax Number:_____

We appreciate your support and will follow up with a patient progress summary.