 

**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)**

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

X\_DSMT: Follow-up- 2 hours

X\_ Medical Nutrition Therapy (MNT) Initial- 3 hours

X\_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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**