HAYWOOD
REGIONAL MEDICAL CENTER

Diabetes and Nutrition Education Center
Referral Form

To schedule an appointment for your patient:
1. **Call** Scheduling at **1-828-452-8814**
2. **Fax** this form *and* most recent office notes to **828-452-8349**

Patient's name: _____DOB: _____

Preferred phone number: _____

Diagnosis:

- o Type 1 Diabetes without complications (E10.9)
- o Type 1 Diabetes with hyperglycemia (E10.65)
- o Type 2 Diabetes without complication (E11.9)
- o Type 2 Diabetes with hyperglycemia (E11.65)
- o Gestational Diabetes (O24.419)
- o Glucose Intolerance (E74.39)
- o Hyperlipidemia (E78.5)
- o Hypertension (I10.0)
- o Obesity (E66.9)
- o Overweight (E66.3)
- o Unintentional Weight loss(R63.4)
- o Failure to Thrive–adult(R62.7) –child (R62.51)
- o Unspecified Protein–Calorie Malnutrition(E46.0)
- o Dietary Counseling and Surveillance (Z71.3)
- o Other: _____

Management Care Plan:

- o Nutrition Management/Medical Nutrition Therapy (1:1)
- o Comprehensive Self–Management Education Program for Diabetes (1:1 initial **and** 8 hours of group education) *This is an American Diabetes Association Recognized Program*
- o Follow–up training for diabetes: Medicare allows 2 hours of follow–up after the initial year of training
- o Management of Diabetes During Pregnancy (1:1)

Labs and Anthropometrics
Please complete or attach most recent office notes with labs:

A1c: _____FBG: _____ Total Cholesterol: _____HDL: _____LDL: _____

Triglycerides: _____ Weight: _____ Height: _____Blood Pressure: _____

FOR PATIENTS WITH DIABETES ONLY who participate in the Self-Management Education Group Series:

Please check any that apply:

- o Newly diagnosed
- o Recurrent elevated blood glucose levels
- o Recurrent hypoglycemia
- o Change in diabetes treatment regimen
- o Retinopathy
- o Neuropathy
- o Hypertension/Cardiovascular Disease/Hyperlipidemia
- o Nephropathy
- o Gastroparesis
- o Impaired dexterity
- o Impaired vision/hearing/ speech
- o Impaired mental status
- o Learning disability
- o Language: _____

Referring Provider: Please print name: _____

Signature of Referring Physician: _____ Date: _____

Time:_____