Albemarle Regional Health Services
Nutrition Program
FAX REFERRAL FORM TO: 252-337-7911
Bertie County Residents FAX to: 252-794-5379
Hertford County Residents FAX to: 252-862-4263
QUESTIONS: Sara Foreman RDN, LDN, CDCES**: 252-338-4370**

DIABETES SELF-MANAGEMENT TRAINING (DSMT) **MEDICAL NUTRITION THERAPY (MNT)**

Patient's Name:_____ Date of Birth:_____ Insurance:_____

Diagnosis, Code - Include ALL pertinent comorbidities/complications:

- ☐ E11.65 Type 2, with Hyperglycemia
- ☐ E10.65 Type 1 with Hyperglycemia
- ☐ E11.9 Type 2, w/o complications
- ☐ E10.9 Type 1, w/o complications

- ☐ 024.410 Gestational, diet controlled
- ☐ 024.919 Unspecified Diabetes in Pregnancy, unspecified trimester
- ☐ 024.911 Unspecified Diabetes in Pregnancy, first trimester
- ☐ 024.912 Unspecified Diabetes in Pregnancy, second trimester
- ☐ 024.913 Unspecified Diabetes in Pregnancy, third trimester

- ☐ R73.09 Pre-Diabetes
- ☐ R73.01 Impaired (elevated) Fasting Glucose
- ☐ R73.02 Impaired Glucose Tolerance Test
- ☐ Chronic Kidney Disease (Ck one ICD-10 code)
  ☐N18.3 ☐N18.4 ☐N18.5

- ☐ R63.4 Abnormal Wt. Loss
- ☐ R63.5 Abnormal Wt. Gain
- ☐ E66.3 Overweight
- ☐ E66.0 Obesity
- ☐ E66.01 Morbid Obesity

- ☐ E78.2 Hyperlipidemia
- ☐ I10 Hypertension
- ☐ E55.9 Vitamin D Deficiency
- ☐ OTHER _____

DIABETES CURRENT TREATMENT

☐Diet & Exercise ☐Please list any exercise restrictions:_____

☐Oral Agents (list/or attach copy):_____

☐Insulin/Dose(s) (list/or attach copy):_____

Indicate one or more reasons for referral if DM:

☐Newly-diagnosed ☐Recurrent elevated blood glucose levels ☐Recurrent Hypoglycemia ☐Change in DM treatment regimen

☐High Risk due to Diabetes Complications/Co-morbid conditions: _____

☐Retinopathy ☐Neuropathy ☐Nephropathy ☐Cardiovascular disease ☐Other: _____

For GDM diagnosis:

Pregravid weight: _____ LMP: _____ EDC: _____ Hx Previous GDM: ☐Yes ☐No

Medicare coverage for DSMT: 10 hours initial DSMT in a 12-month period from the first visit, and 2 hours follow up DSMT per year after that. An additional referral will be required for follow up education. The patient may be eligible for additional MNT hours if needed.

Indicate any existing barriers requiring customized education:

Special Need: ☐Vision ☐Non-Ambulatory ☐Physical Disability ☐Hearing ☐Cognitive ☐Language ☐ Other:_____

Items Required for Referral:

☐ Completed Referral Form ☐ Demographics Sheet ☐ Insurance Card ☐ Medication list ☐ Last Office Notes ☐ Recent Labs

Physician Name: _____Fax #:_____ NPI:_____

➢**Signature:**_____**Date:**_____

****MD Signature required for MNT service****

I hereby certify that I am managing this beneficiary's condition and that the above prescribed training is a necessary part of management.