Queen's Diabetes Education Center Punchbowl - Order Referral Form

Phone: (808) 691-4823 Fax: (808) 691-5399

If you have Carelink (EPIC), please fill out electronic order instead.
NOTE: This form complies with MEDICARE guidelines.

Patient's Name:_____ **D.O.B.** _____ ☐ **Male** ☐ **Female**

Patient's Contact: Home:_____ **Cell:**_____ **Work:**_____

1. **Reason(s) for referral:**
   ☐ New/Recent Diagnosis ☐ Review/Reinforcement ☐ Recurrent Hyperglycemia or Hypoglycemia
   ☐ Lacks previous DSME ☐ Medication Management
   ☐ Dietary/Nutrition:(specify)_____
   ☐ Other:_____

2. **Diagnosis:** (**check all that apply**)
   ☐ **E 11.9** Diabetes Type 2 controlled
   ☐ **E 11.65** Diabetes Type 2 uncontrolled
   ☐ **E 10.9** Diabetes Type 1 controlled
   ☐ **E 10.65** Diabetes Type 1 uncontrolled
   ☐ **E 11.29** Type 2 DM w/ other kidney complications
   ☐ **E 11.22, N 18.**___ DM Type 2 w/ diabetic CKD,Stage___
   ☐ **E 10.22, N 18.**___ DM Type 1 w/ diabetic CKD, Stage___
   ☐ **R73.09** Pre-Diabetes

   ☐ **N 18.**___ Chronic Renal Failure-Stage_____
   ☐ **N 18.9** Chronic Renal Failure, unspecified
   ☐ **Z 94.0** S/P Kidney Transplant (<36 months)
   ☐ **E 78.5** Hyperlipidemia, unspecified
   ☐ **I 10** Hypertension, essential (primary)
   ☐ **E 66.9** Obesity, unspecified
   ☐ _____ **Other**:_____

3. **Service(s) Requested:**
   ☐ **Diabetes Self Management Education (DSME)**
   ☐ **GROUP Diabetes Self Mangement Education (DSME)**
   ☐ **INDIVIDUAL Diabetes Self Management Education (DSME)**
   Special need(s) supporting referral for Individual Education *(Required by Medicare):*
   ☐ Impaired Vision ☐ Impaired Hearing ☐ Impaired mobility/Dexterity ☐ Language Barriers
   ☐ Learning Disability ☐ Impaired Mental Status/Cognition ☐ 13 to 18 years of age ☐ Other: _____

   Diabetes Self-Management Education (DSME) Content
   Includes Individual Assessment and **ALL TOPICS** listed below for a **total of 10 hours** unless otherwise indicated
   ☐ **ALL TOPICS** (recommended option, comprehensive DSME)
   ☐_____hours; please specify topics requested:
   ☐ Disease Process
   ☐ Nutrition
   ☐ Exercise
   ☐ Medication
   ☐ SMBG/Monitoring
   ☐ Stress Management/Adjustment & Support
   ☐ Risk Reduction
   ☐ Problem Solving
   ☐ Goal Setting

   ☐ **Annual/Post Program Follow Up DSME (patient previously attended DSME)**
   Note: Medicare covers 10 hours initial DSME and 2 hours follow up each calendar year.

   ☐ **MEDICAL NUTRITION THERAPY (MNT) (DIETITIAN)**
   Note: Medicare allows 3 hours in the first year then 2 hours follow up each calendar year. Medicare covers DM/CKD/CRF/Renal Transplant Only.

   ☐ **Diabetes Medication Management/ Insulin Dose Titration and Adjustment (APRN)**
   ☐ **Blood Glucose Meter Training**
   ☐ **Insulin and Non-Insulin Injectables Instruction *(Please FAX copy of Rx)***

4. **Self Monitoring Blood Glucose Goals (SMBG and A1c):**
   ADA SMBG and A1c goals will be used unless otherwise specified (Plasma: Fasting= 80-130; PP <180 1-2 hr; A1c= 6.5-7.0%)
   If not using ADA goals, please indicate the patient's goals:
   Fasting / Pre-prandial:_____**mg/dL** **1-2 Hr Post-prandial:**_____**mg/dL** **HS:**_____**mg/dL** **A1c:**_____

5. **Exercise Recommendation:**
   ☐ No Limitations ☐ Limitations, as follows: _____

IF YOU ARE NOT ON CARELINK, PLEASE FAX REFERRAL TO (808)691-5399 ALONG WITH THE FOLLOWING:

☑ **Copy of the latest original lab values: • Fasting Glucose • HbA1c • Lipid Profile • Chemistry • Urine Micro-albumin**
☑ **Patient's current H&P and recent Progress Notes pertinent to diagnosis**
☑ **List of patient's medications prescribed and/or taking, meter type and test supplies being used**
☑ **Copy of Patient's insurance card(s)**

I certify that the education is medically appropriate and needed for the above patient.

Physician's Name **(please print)**: _____NPI: _____

If this is a **Medicare** Patient, Referring Physician must be a Medicare Provider. Are you a Medicare Provider? ☐ **Yes** ☐ **No**

Physician's Signature:_____Date: _____

Physician Phone Number:_____ Physician Fax Number:_____