MYDIABETESTUTOR

REFERRAL FORM

FAX 844.306.5999

Thank you for the referral to My Diabetes Tutor. Please fax this completed and SIGNED form to 844-306-5999, **along with a copy of insurance cards, demographics, recent A1C, and other supporting labs and notes necessary for services.**

PART I PATIENT INFORMATION

Full Name	Date of Birth	Gender ☐ Male ☐ Female ☐ Unknown ☐ Other
Phone Number	Patient Email Address	Primary Language

Check Diabetes Type

☐ **Type 1** ☐ **Type 2** ☐ **Prediabetes** ☐ **Gestational** ☐ **Pre-existing Diabetes in Pregnancy**

ICD10 code

MNT Diagnosis

ICD10 code

A1C (within 3 months of referral) %	Date	LAB Preferred

PHARMACY preferred		Pharmacy Phone
Provider Name	Phone	Fax

Provider Practice Name	Next Provider Visit

INSURANCE Name

REFERRING Entity

☐ **Adventist** ☐ **Alignment** ☐ **Aria** ☐ **Dignity** ☐ **Kaweah** ☐ **Sante** ☐ **Tricare** ☐ **United** Other

PART II DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT (DSMES)

Check education/training needed:

☐ **Initial DSMES 10 (or hours) - New diagnosis, or no prior diabetes education.**
Includes nine standard topic areas based on meeting individualized needs and reporting back to referring provider.
☐ **Annual DSMES (2 hours) - Health maintenance, complication prevention, new factors influencing self-care.**
☐ **Device Training (1:1 visits) - choose one:** ☐ **CGM Training** ☐ **Insulin Pump Start** ☐ **Insulin Pump Ongoing Training**
☐ **Additional DSMES for change in medical condition/treatment.**

List visit type

☐ **Individual.** Reason(s): ☒ **no groups within 2 months** ☐ **virtual / distance** ☐ **language** ☐ **vision** ☐ **hearing** ☐ **mobility** ☐ **cognition**
☐ **Group**

PART III MEDICAL NUTRITION THERAPY (MNT)*

Check MNT needed:

☐ ***Required for MNT. Approve number of hours authorized by insurance.**
☐ **Initial MNT 3 hours** ☐ **Annual follow-up MNT 2 hours** ☐ **Additional MNT hours for change in medical condition / diagnosis**

PART IV REMOTE PATIENT MONITORING (RPM), CHRONIC CARE MANAGEMENT (CCM), ENDOCRINOLOGY PROVIDER CONSULT

Check service type needed:

☐ **RPM: I verify patient provides consent to verify insurance and I approve number of hours authorized.**
☐ **CCM: I verify patient provides consent to verify insurance and I approve number of hours authorized.**
☐ **Endocrinology provider consult**

I affirm managing this patient's medical condition and that the above referral is a necessary part of their management.

Provider NPI#	Provider Signature REQUIRED for Services	Date