MDT Referral Form

Thank you for choosing to refer your patient to *My Diabetes Tutor*. To start the referral process, please complete this form and *fax to 844-306-5999*. **Please send copy of insurance cards, demographics, labs, notes, and any notes supporting the referral. Referrals with incomplete information cannot be scheduled.**

Patient Information:

Name: ____ **Date of Birth:**____________________

Cell Phone: ___________________________ **Patient Email:** _________________________________

Primary Language _____________________ **Gender: Male Female Not specified**

Insurance Name: ________________________________ **Preferred Lab:**________________________

Preferred Pharmacy:_____________________________ **Pharmacy Phone:**______________________

Referring Provider Name Phone and Fax:____

Referring Provider Practice Name:__________________________ **Phone:**_______________________

Referred from: (circle one) **Dignity Health. Tricare Adventist Health United Health Centers**

Aria Health Center Alignment Health Other____

Provider Name____________________________________ **Next appt with Provider**_______________

Please send recent labs that support diagnostic criteria for patient eligibility and outcome monitoring.

Type 1 _______ Type 2 _______ Gestational_______ Prediabetes _______

MNT Diagnosis ___________________________ Dx code________________

Diabetes Self-Management Education & Support/Training (DSMES/T)

Check type of training services and number of hours requested

__ Initial DSMES/T 10 or ____hours (new diagnosis or no prior diabetes education)

__ Follow-up DSMES/T 2 hours

__ Device Training (circle one). Insulin Pump or CGM Training

__ Additional DSMES/T for change in medical condition or treatment

Medical Nutrition Therapy (MNT) *Check the type of MNT requested*

__ Initial MNT 3 hour

___Additional MNT hours for change in medical condition/diagnosis:

__ Annual follow-up MNT 2 hours

Remote Patient Monitoring: ___ *(please check) with patient agreed consent/verification of insurance*

Number of Educational/MNT/RPM Visits Authorized: _______________ **Expiration Date:** ______________

Physician Signature/NPI # ____ **Date:** ______________

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Patient Baseline Data – Labs within 3 months of Referral

****Referrals with incomplete information cannot be scheduled, except for Blood Pressure and Vit D.**

Patient Name_______________________________ **DOB**_________________

	Value	Date
HbA1C		
Weight		
Height		
Blood Pressure (if available)		
Total Cholesterol		
HDL		
LDL		
Triglycerides		
Urinary Microalbumin (positive or negative)		
Vitamin D (if available, if not, please order) **Order date:** ______		
EGFR		
Annual Foot Exam	YES or NO	
Annual Eye Exam	YES or NO	

CALL 559.530.3396
TEXT 559.212.4809
FAX 844.306.5999

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