



Location:
 Cass City
 Marlette

Diabetes Education Services
 3006 Main St, Marlette
 Phone: 989-635-4348
 Fax: 989-635-4315
 6667 Main St, Cass City
 Phone: 989-912-6368
 Fax: 912-872-5441

DIABETES EDUCATION SERVICES REFERRAL FORM

Patient's Name:		DOB:	
Address:			
Daytime Phone:			
Insurance:		Policy #:	Prior Auth #:
PLEASE CHECK THE TYPE OF DIABETES SELF-MANAGEMENT TRAINING (DSMT) or MEDICAL NUTRITIONAL THERAPY (MNT) SERVICES			
<input type="checkbox"/> INITIAL DSMT, COMPREHENSIVE (10 HRS covering p-l content areas) <input type="checkbox"/> FOLLOW-UP DSMT (2 HRS per year following completion of the comprehensive DSMT Program) <input type="checkbox"/> MEDICAL NUTRITION THERAPY(MNT), INITIAL (3 HRS with RD) <input type="checkbox"/> FOLLOW-UP MNT (2 HRS per year following completion of initial MNT) <input type="checkbox"/> SPECIFIC TOPICS & HRS (If needs vary from above): _____			
PLEASE CHECK ANY BARRIERS TO GROUP LEARNING OR ADDITIONAL INSULIN TRAINING REQUIRING 1:1 EDUCATION (*leave blank if none)			
<input type="checkbox"/> IMPAIRED MOBILITY <input type="checkbox"/> IMPAIRED DEXTERITY <input type="checkbox"/> IMPAIRED HEARING <input type="checkbox"/> IMPAIRED VISION <input type="checkbox"/> LEARNING DISABILITY <input type="checkbox"/> IMPAIRED MENTAL/COGNITIVE STATUS <input type="checkbox"/> LANGUAGE BARRIER <input type="checkbox"/> INSULIN TRAINING <input type="checkbox"/> OTHER (Please Specify): _____			
PLEASE CHECK DIABETES DIAGNOSIS			
<input type="checkbox"/> T2DM, UNCONTROLLED <input type="checkbox"/> T1DM, UNCONTROLLED <input type="checkbox"/> GESTATIONAL DM		<input type="checkbox"/> T2DM, CONTROLLED <input type="checkbox"/> T1DM, CONTROLLED <input type="checkbox"/> DIABETES with PREGNANCY	
PLEASE INDICATE PATIENT'S CURRENT THERAPIES, SMBG Schedule, & LABS			
<input type="checkbox"/> ORAL/INJECTABLE MEDS: _____ <input type="checkbox"/> SMBG (specify frequency): _____ LABS/DATE: HbA1c: _____ / _____ FBG: _____ / _____ BUN: _____ / _____ Cr: _____ / _____ Microalbumin: _____ / _____ GFR: _____ / _____ Total Chl: _____ / _____ HDL: _____ / _____ LDL: _____ / _____ Trig: _____ / _____			
PLEASE SIGN & DATE			
Physician's Name (printed):		Office Phone #:	
		Office Fax #:	
Physician's Signature:		Date:	
*MNT must be ordered by a MD or DO		*DSMT may be ordered by a MD, DO, or Midlevel Provider	