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: 989-872-5441

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

□ INITIAL DSMT, COMPREHENSIVE (10 HRS covering all content areas)
□ FOLLOW-UP DSMT (2 HRS per year following completion of the comprehensive DSMT Program)
□ MEDICAL NUTRITION THERAPY(MNT), INITIAL (3 HRS with RD)
□ FOLLOW-UP MNT (2 HRS per year following completion of initial MNT)
□ 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)

□ IMPAIRED MOBILITY □ IMPAIRED DEXTERITY □ IMPAIRED HEARING □ IMPAIRED VISION
□ LEARNING DISABILITY □ IMPAIRED MENTAL/COGNITIVE STATUS □ LANGUAGE BARRIER
□ INSULIN TRAINING □ OTHER (Please Specify):_____

PLEASE CHECK DIABETES DIAGNOSIS

□ T2DM, UNCONTROLLED
□ T1DM, UNCONTROLLED
□ GESTATIONAL DM
□ T2DM, CONTROLLED
□ T1DM, CONTROLLED
□ DIABETES with PREGNANCY

PLEASE INDICATE PATIENT'S CURRENT THERAPIES, SMBG Schedule, & LABS

□ ORAL/INJECTABLE MEDS:_____
□ 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