

DIABETES CARE & EDUCATION REFERRAL

BORGESS

FAX COMPLETED FORM TO (269) 226.7911.

Physician signature on this form is required.
Please include a copy of lab results within the past 90 days (A1C, glucose, microalbumin, lipids) to expedite referral.

Diabetes Center
1722 Shaffer Street, Suite 3
Kalamazoo, MI 49048
(269) 226.8321
(269) 226.7911 Fax

Referring Physician	Contact Person	Today's Date
Office Address		Office Phone

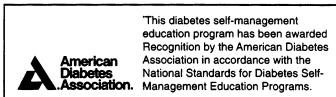
PATIENT INFORMATION

Name (Last)	(First)	(M.I.)
Address		
City	State	ZIP
D.O.B.		
Home Phone	Work Phone	Cell Phone
Insurance(s) to be billed <input type="checkbox"/> Please provide photocopy of front and back of card		

CONSULTATION WITH DR. MICHAEL VALITUTTO

PLAN OF CARE

Request consultation and treatment for:	Diabetes Education – Diabetes Self Management Training (DSMT)
Diabetes	Full program up to 10 hours of education
Other:	Full program up to 10 hours of education and 3 hours of Medical Nutrition Therapy (MNT)
Please send all pertinent documentation regarding patients care such as, office notes, diagnostic tests and/or recent labs	Special needs—Patient unable to participate in group classes due to the following special needs: <input type="checkbox"/> Vision <input type="checkbox"/> Language <input type="checkbox"/> Hearing <input type="checkbox"/> Other:
	Additional Services – Diabetes Self Management Training (DSMT order required for any services below)
WRITTEN DIAGNOSIS	Blood glucose monitoring (please write script for meter and supplies)
Type 1	Gestational diabetes (includes glucose monitoring)
Type 2 <input type="checkbox"/> Diet <input type="checkbox"/> Orals <input type="checkbox"/> Insulin	Insulin instruction/other diabetes injectables Type: _____ Dose: _____
Gestational Due Date: _____	Oral medications: <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue
Pre-Diabetes	Insulin adjust (by Diabetes nurse)
Other:	Insulin pump therapy
	Foot Care
MEDICAL CONDITION	Initial Medical Nutrition Therapy (MNT) without DSMT
Initiation of/change in oral therapy	Up to 3 hours
New to insulin	Review & Refresher Options
Uncontrolled diabetes	Annual DSMT follow-up (2 hours)
Severe hypo/hyperglycemia requiring assistance, ER visits or hospitalization	Annual MNT follow-up (2 hours) (please check medical condition on form)
Obesity	Additional MNT (second referral in same year due to changes in condition or diagnosis)
Knowledge/skills deficit	Specify: _____ Hours: _____
Complications:	Additional Instructions
Other:	



NOTE TO PHYSICIAN: DSMT & MNT are individual and complementary services to improve diabetes care. Research indicates that MNT combined with DSMT improves outcomes. DSMT includes nutrition, exercise, monitoring, psychological adjustment, problem solving-goal setting, diabetes disease process, medications, complications and, when necessary, pre-conception planning.

For Internal Use Only	Referral Date:
Group Class Date:	
Time:	Location:
Individual Ed Date:	
Time:	Location:

Physician Signature (required by MDCH & Insurance)

Date