St. Charles HEALTH SYSTEM

**OUTPATIENT REFERRAL FORM**
**NUTRITION AND DIABETES EDUCATION**

**PHONE: 541-706-6348 FAX: 541-598-3437**

**Service Locations:** Bend, Redmond, Prineville, Madras

| PATIENT LEGAL NAME | DATE OF BIRTH | PATIENT PHONE | |
|---|---|---|---|
| INSURANCE NAME | MEMBER/POLICY ID | | |
| REFERRING PROVIDER NAME | PROVIDER PHONE | PROVIDER FAX | |
| DIAGNOSIS/SYMPTOMS | | **ICD 10** | **EDD (if patient is pregnant)** |

## STEP 1: TYPE OF EDUCATION *(may select more than one)*

☐ **Medical Nutrition Therapy (MNT)** (2 hours or ____ ) **--- include relevant chart notes and labs**
Personalized instruction with a registered dietitian that incorporates diet therapy counseling for a nutrition related diagnosis using evidence-based guidelines.

MNT service requested *(circle and/or indicated other below):* Diabetes, Eating Disorder, Pediatrics, Weight Management, Bariatric Surgery, Gastrointestinal Disorders, Cardiovascular Disease.
Other: _____

☐ **Diabetes Self-Management Education and Support (DSMES)** (10 hours or _____ ) **--- include relevant chart notes, medication list and labs (A1c, Fasting BG, Random BG, OGTT, etc.)**
Includes colaborative education, support, goal setting for type1, type 2 and gestational diabetes around coping, eating, activity, medication, monitoring, problem solving and reducing risks.

DSMES service requested *(circle and/or indicate other below):* Gestational Diabetes, Glucose Monitoring, Medication Instruction (attach orders and titration follow-up plan), New Diagnosis, Pediatrics, Personal Continuous Glucose Monitor Training, Glucagon Training.
Other: _____

☐ Initiate insulin or other medication as directed **(attach orders and titration follow-up plan)**
☐ Continue oral diabetes meds ☐ Discontinue oral diabetes meds
☐ Other: _____

## STEP 2: Priority ☐ Routine ☐ Urgent

## STEP 3: Special Needs *(Check all that apply.)*

☐ No special needs
☐ Hard of hearing
☐ Learning/developmental disability
☐ Food insecurity
☐ Interpreter need for language: _____
☐ Low vision
☐ Physical disability/limited mobility
☐ Emotional disorder/mental health disability
☐ Communication disability
Other: _____

## STEP 4: Sign below and fax this form to 541-598-3437

Referring Provider Printed Name_____

Referring Provider Signature _____ Date _____

Medicare requires that each referral contain patient demographics/ICD 10 code, type of education requested, special needs (as applicable), recent labs and medication list, and referring provider signature. Fax this form or the requested information in any format.