



Diabetes and Nutrition Therapy Center Order Form (DSMT and MNT services)

Date: _____

Patient's Last Name First Name Middle DOB: _____

Insurance Type Pre-Certification # _____

Referring Practitioner (MD required for MNT referrals): _____

Diagnosis:

(Please fax recent labs for outcomes evaluation and Medical History to 585-396-6915)

Type 1 controlled **Other:** _____
Type 2 controlled _____
Gestational Diabetes

Complications/Cormorbidities (check all that apply):

Hypertension **Dyslipidemia** **Retinopathy** **PVD**
Neuropathy **Nephropathy** **Stroke** **CHD**
Non Healing Wound **Renal Disease** **Pregnancy** **Obesity**
Mental/Affective Disorder

Diabetes Self Management Training (DSMT)

(Check type of education services being ordered)

Comprehensive Management Skills Group Class: Two, three hour group sessions

1:1 Nutrition Management (with Tami Best, MS, RD, CDN, CDE)

1:1 Nurse Diabetes Educator (with Jane Hallstead, RN, MSN)

Identify Education Needs:

Insulin Instruction Glucose Monitoring Complications Instruction

Management of Diabetes During Pregnancy

***Please provide reason for requesting 1:1 consultation:** _____

Diabetes Medications:

(Specify type, dose frequency)

Oral: _____ Insulin: _____

Medical Nutrition Therapy (with Kacie Deats, RD, CDN):

(Check services being ordered)

Initial MNT

Please specify diagnosis, medical condition, or treatment regimen: _____

Physician Signature: _____

Thank you for your referral to The Diabetes and Nutrition Therapy Center at Thompson Health

Fax Order Form, Current Labs, and Medical History to 585-396-6915. To schedule an appointment, please call 585-396-6910.