Duke Primary Care Diabetes and Nutrition Education Referral Form

Phone **919-470-6505** Fax **919-470-8199**

Please fax to 919-470-8199 with recent lab/notes and insurance information.

Referring Physician Signature (required): _____

Date: _____ **Time:** _____

Clinic Name: _____ **Contact Person:** _____

Clinic Phone: _____ **Clinic Fax:** _____

Patient Information

Name: _____ **DOB:** _____

Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Other Phone:** _____

Patient has special need(s) requiring individual instruction due to: _____

☐ Vision ☐ Hearing ☐ Language ☐ Physical ☐ Cognitive ability ☐ Other (specify)

PCP Must Determine Dx Code(s)

Diabetes diagnosis 5 digit code _____

☐ Type 1 controlled ☐ Type 2 controlled
☐ Type 1 uncontrolled ☐ Type 2 uncontrolled

Complications and other diagnosis

☐ Hypertension ☐ Dyslipidemia
☐ Neuropathy ☐ Nephropathy
☐ Retinopathy ☐ Obesity
☐ Stroke ☐ PVD
☐ Gastroparesis ☐ CHD
☐ Mental Health Problem
☐ Other _____

☐ **Gestational diabetes** Dx code _____
☐ Type 1 and pregnant
☐ Type 2 and pregnant

☐ **Pre-diabetes (IGT or IFG)** Dx code _____

Check Type of Education Needed:

☐ **Diabetes self-management training (DSMT):**
Diabetes & nutrition classes (up to 10 hrs) and additional medical nutrition therapy (MNT) (up to 3 hrs) if needed.

☐ **Continuous Glucose Monitor (CGM) Training**
☐ **Insulin administration or other diabetes injections**
☐ **Insulin to carbs ratio/plan**
☐ **Other (specify topic and no. of hrs):** _____

☐ **2nd referral (same year) for additional MNT due to change in condition or Dx (specify):** _____

Review and refresher options
☐ Annual review (2 hrs)

☐ **Gestational Diabetes class**
☐ Other _____

☐ **Pre-diabetes class or appointment**

Duke Primary Care