Providence

Outpatient Referral Form

Providence Nutrition and Diabetes Education Services—Oregon

PHONE: 855-360-5456 FAX: 503-215-6240

Office Hours: M-Th 8 a.m-7 p.m., F 8 a.m-4:30 p.m.

35 Service Locations: Portland Metro Area / Clark County Washington, Southern Oregon, Hood River, Yamhill County

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 indicate other below)*: Diabetes, Eating Disorder, Pediatrics, Weight Management, Culinary Classes

Other: _____

☐ **Diabetes Prevention Program (DPP)** (32 visits)

CDC recognized lifestyle change program to prevent or delay type 2 diabetes. Eligibility criteria: at least 18 years old, not pregnant, BMI >25 (>23 if of Asian decent), recent blood test within prediabetes range, no previous diagnosis of type 1 or 2 diabetes, no ESRD, able to participate in regular activity and keep daily logs of food/activity.

☐ **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 collaborative education, support, goal setting for type 1, 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, Culinary Classes

Other: _____

- ☐ Initiate insulin or other medication as directed **(attach orders and titration follow-up plan)**
  - ☐ Continue oral diabetes meds ☐ Discontinue oral diabetes meds
- ☐ Initiate and titrate insulin according to Providence protocol
- ☐ 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 503-215-6240

Referring Provider Signature _____ Date _____

Medicare requires that each referral contain patient demographics, diagnosis/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.