Date: _____

Referral Form

PMH Outpatient Nutrition, Diabetes Education & Community Teaching Kitchen

Patient Information:

Name: _____ Date of Birth: _____
Address: _____
Phone (Home): _____ Phone (Work): _____

Providence Milwaukie Community Teaching Kitchen Services: Please select all that apply

Referral to PMH Outpatient Nutrition & Diabetes Education

- ☐ Medical Nutrition Therapy (Initial/Subsequent)
- ☐ Medical Nutrition Therapy (Interactive Group Cooking Course – ***Culinary Nutrition***
- ☐ Diabetes Education **(Complete page 2 for type of treatment requested)**

****Note: Traditional Medicare, only covers nutrition counseling for *diabetes and renal disease*.**

Referral to PMH Community Teaching Kitchen

- ☐ Food Insecure? (Check if yes, ICD-10 code Z59.4)

Diagnosis: Please check all that apply

	ICD-10
☐ Abnormal Weight Gain	R 63.5
☐ Anorexia Nervosa	F50.0
☐ Bulimia Nervosa	F50.8
☐ Other Eating Disorder	F50.9
☐ Cancer (type): _____	_____
☐ Celiac Sprue	K90.0
☐ CHF	I 50.20
☐ DM II	E11.9
☐ GERD	K21.9
☐ Hypercholesterolemia	E78.0
☐ Hyperlipidemia	E78.4
☐ Hypertension	I10
☐ Hypoglycemia	E16.2
☐ Other: _____	_____

MD/DO: Please adjust ICD-10 codes as needed

	ICD-10
☐ Impaired Fasting Glucose	R73.01
☐ Pre-Diabetes NOS	R73.09
☐ IBS w/ Diarrhea	K58.0
☐ Morbid Obesity	E66.01
☐ Obesity	E66.9
☐ PCOS	E28.2
☐ Pregnancy	Z34.80
☐ Renal Disease (type): _____	_____
☐ Underweight, BMI <19	R63.6
☐ Protein/Calorie Malnutrition – Severe	E43.0
☐ Malnutrition – Moderate	E44.0
☐ Malnutrition – Mild	E44.1
☐ Loss of Weight (Abnormal)	R63.4
☐ Other: _____	_____

Additional Comments Including Special Needs: *(check all that apply)*

☐ Vision/Hearing ☐ Impaired mobility/dexterity ☐ Impaired Mental Status ☐ Learning Disability
☐ Interpreter needed/Language: _____
☐ Other: _____

Medical Nutrition Therapy & Diabetes Education	Food Insecurity
PMH Outpatient Nutrition Providence Milwaukie Medical Plaza, Building 101 10202 SE 32nd Ave. Milwaukie, OR 97222 Phone: 855-360-5456 **Fax: (503) 215-6240**	**PMH Community Teaching Kitchen** Providence Milwaukie Medical Plaza, Building 101 10202 SE 32nd Ave. Milwaukie, OR 97222 Phone: 503-513-8067 **Fax: (503) 513-8052**

_____ _____ _____
Provider Name **Provider Signature** **Provider Phone Number**

Date: _____

Referral of Diabetes Education: Please complete ALL 3 steps

STEP 1: TYPE OF TRAINING *(Check all that apply and/or specify under Step 2 Special Instructions)*

☐ **Comprehensive Diabetes Education**
(10 hours or _____)

☐ **Continuous Glucose Monitor**
Education and training for:
☐ Personal Use

☐ **Diabetes Prevention Program** (26 visits)
Follows CDC Curriculum

☐ **Medical Nutrition Therapy**
(2 hours or _____)
Nutrition focused education

☐ **Diabetes During Pregnancy**
EDD: _____
Specify: ☐ Type 1 ☐ Type 2 ☐ Gestational Diabetes

☐ **Other education** (Please specify) **:**

Insulin & Injectables
All prescription must be submitted by referring provider

☐ **Initiate Insulin as directed below:**
Type:
Dose:
Timing:
Administration mode: Pen Vial
Continue Oral meds: Yes No
Titration follow-up plan:

☐ **Initiate and titrate insulin according to Providence Protocol:**
Type:
Administration mode: Pen Vial
Continue Oral meds: Yes No

☐ **Other injectable:**
Type:
Dose:
Timing:
Titration follow-up plan:

STEP 2: SPECIAL INSTRUCTIONS

STEP 3: CURRENT CLINICAL DATA *Specify or attach lab report and medication list*

Date of lab values: _____

HbA1c: _____ Fasting BG: _____

Random BG: _____

OGTT 1 hr._____ 2 hr. _____ 3 hr. _____

Diabetes and other pertinent medications/doses:

_____

_____

STEP 4: SIGN BELOW AND FAX THIS FORM.

By signing this form, I certify that I am managing the patient's diabetes and the training described is needed to ensure therapy compliance or to provide the beneficiary with the skills and knowledge to help manage their diabetes.

Physician's signature _____ Date _____