CentraState Medical Center
Novo Nordisk Diabetes Center

I, the treating physician or qualified non-physician practitioner, am referring this patient for medically necessary DSME/T and/or MNT.

Please complete this form, sign, and fax to the appropriate location.

☐ Novo Nordisk Diabetes Center
Phone: 732.294.2574
Fax: 732.294.2575

☐ To schedule an appointment:
Centralized Scheduling
732.294.2778 option 3

Patient Information:

Last Name: ______________ Date of Birth: ______________ Day Phone: ______________
First Name: ______________ SSN: ______________ Night Phone: ______________
Insurance: ______________ Address: ______________

Diagnosis: Please check all applying to this referral.

☐ E11.__ __ __ __ :T2DM ______________
☐ E11.65: T2DM with hyperglycemia
☐ E11.8: T2DM with unspecified complications
☐ E11.9: T2DM without complications
☐ E10. __ __ __ __ :T1DM ______________
☐ E10.65: T1DM with hyperglycemia
☐ E10.8: T1DM with unspecified complications
☐ E10.9: T1DM without complications
☐ Z79.4: Long term/current use of insulin
☐ Z96.41: Presence of insulin pump

☐ O24.019: Pre-existing DM, T1, pregnancy, unspecified trimester
☐ O24.119: Pre-existing DM, T2, pregnancy, unspecified trimester
☐ O24.410: GDM, pregnancy, diet controlled
☐ O24.414: GDM, pregnancy, insulin controlled
☐ E08:_ _ _ _ DM due to underlying condition
☐ R71.01: Impaired fasting glucose
☐ R73.02: Impaired glucose tolerance (oral)
☐ N18.4: Chronic kidney disease, stage 4
☐ Other – Include ICD-10 code and description if not listed above:
____

Plan of Care: Check desired services.

☐ **Initial Comprehensive DSME/T*:** Includes 9 hours Group and 1 hour 1:1 in a 12-month period unless hours/content otherwise noted in Alternative DSME/T Hours and Content section.

☐ **Refresher/Follow-up DSME/T*:** 2 hours Group or 1:1 (unless hours otherwise noted: ____ hours)

☐ **Prediabetes DSME/T*:** 1 hour Group or 1:1 (Not reimbursed by Medicare)

☐ **Pregnancy DSME/T*:** 4 hours Group and 1 hour 1:1 (Can include education related to preconception, prenatal and/or postpartum)

☐ **Alternative DSME/T hours and Content:**
____ hours, ☐ Disease Process and Treatment, ☐ Coping, ☐ Nutritional Management, ☐ Physical Activity, ☐ Monitoring, ☐ Acute Complication Risk Reduction, ☐ Chronic Complication Risk Reduction, ☐ Medication, ☐ Behavior Change/Goal Setting

☐ **Insulin Training:** 1 hour Group or 1:1 Educator may adjust insulin per protocol:
☐ Yes ☐ No Insulin Prescription: ________
____
____

☐ **New to Insulin Pump Therapy Training:** (Includes assessment, pump start, insulin adjustment and follow-up)
Insulin Pump Prescription: ______________
____

☐ **Insulin Pump Therapy Upgrade Training:**
Insulin Pump Prescription: ______________
____

☐ **Professional Continuous Glucose Monitoring (CGM) Sensor Training:** (72-hour minimum; Includes placement, training and removal)

☐ **Personal CGM Sensor Training:** (Includes hookup and training)

☐ **Initial MNT:** 3 hours (unless hours otherwise noted: ______ hours). Visit Reason:
____

☐ **Follow-Up MNT:** 2 hours (unless hours otherwise noted: ______ hours). Visit Reason:
____

☐ **Additional MNT:** _____ hours (in addition to initial/follow up due to change in medical condition, treatment and/or diagnosis)
Specify change: ______________
____

☐ **Other:** ______________
____

***Content delivered per assessment:**
Disease Process and Treatment, Coping, Nutritional Management, Physical Activity, Monitoring, Acute Complication Risk Reduction, Chronic Complication Risk Reduction, Medication, Behavior Change/Goal Setting

Special Needs: Patient has special needs and requires individual (1:1) DSME/T instead of group DSME/T. Check all that apply.

☐ Cognitive impairment ☐ Physical impairment ☐ Language limitation ☐ Interpreter needed
☐ Hearing impairment ☐ Sight impairment ☐ Vision impairment ☐ Other: ______________

Lab Results/Anthropometrics: Please FAX labs (A1C, Lipids, BP, UACR, GFR)

☐ Labs in [Insert Electronic Health Record System Name]

	Result		Date		Result		Date		Result		Date
Fasting BG:	______	mg/dL	______	1-hr OGTT:	______	mg/dL	______	3-hr OGTT:	______	mg/dL	______
Random BG:	______	mg/dL	______	2-hr OGTT:	______	mg/dL	______	HbA1c:	______	%	______
Height:	______	inches	______	Weight:	______	kg	______	GFR:	______	mL/min/1.73m²	______

Provider Name (Print): ______________ **Provider Signature:** ______________

Provider NPI: ______________ **Provider Phone:** ______________ **Date:** ______________