

**Martha
Jefferson Hospital**

**Referral for Diabetes Education and Nutrition Services @
MJH HealthWise House, 509 Locust Ave, Charlottesville, VA 22902**

Patient Information (Please PRINT)

Please Fax completed form to: **(434) 654-4411**

Patient's Last Name		First	Middle Initial	Social Security # :	
Address		City	State	Zip	
DOB:	Home Phone #	Work #	Cell#	Referring Physician:	

ALL FIELDS BELOW MUST BE COMPLETED FOR REIMBURSEMENT:

Appointment/Class Date and Time: _____ **with** _____

Insurance pre-authorization number:	Number of Visits:	Effective dates:
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Reason for Referral - check ALL that apply

<input type="checkbox"/>	New onset diabetes				
<input type="checkbox"/>	Change in diabetes treatment regimen (from no meds to oral meds, or oral meds to insulin)				
<input type="checkbox"/>	High risk due to complications of diabetes				
<input type="checkbox"/>	DM with episodes of hypo or hyperglycemia requiring ER or hospitalization				
<input type="checkbox"/>	DM -Poor control (A1C>8.5 on 2 occasions within past 12 months, 3 or more months apart)				
<input type="checkbox"/>	Nutrition counseling – specify diagnoses below				
<input type="checkbox"/>	Nutrition counseling in preparation for bariatric surgery (specify):	<input type="checkbox"/>	Lap band	<input type="checkbox"/>	Gastric bypass

Services Requested – check all that apply - if not specified, to be determined by educator

<input type="checkbox"/>	Group diabetes education – includes nutrition, exercise, medication, monitoring, problem solving, goal setting, prevention of short and long-term complications.	
<input type="checkbox"/>	Identified barriers to group education (vision, hearing, special needs, 1:1 requirements)	
<input type="checkbox"/>	1:1 diabetes education with RN and/or RD	
<input type="checkbox"/>	1:1 Nutritional Counseling/Medical Nutrition Therapy	
<input type="checkbox"/>	1:1 Gestational Diabetes management	
<input type="checkbox"/>	1:1 Insulin Training	1:1 Insulin Pump Training
<input type="checkbox"/>	1:1 Meter Training	Other:

Last AIC _____
Date: _____
Please FAX a copy of ALL recent labs with referral, or check <input type="checkbox"/> if labs available through MJH lab (Powerchart).

Diagnosis – check all that apply

<input type="checkbox"/>	Cardiovascular Disease 429.2	<input type="checkbox"/>	Hypertension (benign) 401.9
<input type="checkbox"/>	Celiac Sprue 579.0	<input type="checkbox"/>	Impaired Fasting Glucose 790.21
<input type="checkbox"/>	DM type 1, controlled 250.01	<input type="checkbox"/>	Impaired Glucose Tolerance 790.22
<input type="checkbox"/>	DM type 1, uncontrolled 250.03	<input type="checkbox"/>	Metabolic Syndrome 277.7
<input type="checkbox"/>	DM type 2, controlled 250.00	<input type="checkbox"/>	Nephropathy 583.9
<input type="checkbox"/>	DM, type 2, uncontrolled 250.02	<input type="checkbox"/>	Neuropathy 355.9
<input type="checkbox"/>	Eating Disorder 307.50 <input type="checkbox"/> Anorexia 307.1	<input type="checkbox"/>	Obesity 278.00 <input type="checkbox"/> Morbid obesity 278.01
<input type="checkbox"/>	Gestational DM, undelivered 648.83	<input type="checkbox"/>	Pre-diabetes 790.29
<input type="checkbox"/>	Hypercholesterolemia 272.0	<input type="checkbox"/>	Retinopathy 362.10
<input type="checkbox"/>	Hypertriglyceridemia 272.1	<input type="checkbox"/>	Underweight 783.22
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

Physician or PCP's Signature (required):	Date:
(A physician or primary care provider's signature is required for insurance reimbursement)	