# Macon County Public Health Nutrition Services Referral Form

Print Form

Macon County Public Health

**Macon County Public Health Nutrition and Diabetes Education Services**

April Innis MHS,RD,LDN, CDE
**828-349-2455**
1830 Lakeside Drive
Franklin NC 28734

**Date of Referral:** _____

Please Fax completed referral order to:
(828) 524-6154
Attn: April Innis

## Patient Data

Name: _____ Height: _____ Date: _____
DOB: _____ Weight: _____ Date: _____
Phone #: _____ Insurance: _____
Interpreter Needed: _____

**** Please attach patient demographics, relevant labs, problem lists and medication info***

**Please indicate below which program you are referring the patient for and complete the information in the corresponding box**

### ☐ Diabetes Education (DSMT/DSME)

**Diabetes Diagnosis:**
☐ Type1 (ICD-10: E10) ☐ Type 2 (ICD-10: E11)
☐ Gestational Diabetes (ICD-10: O24.41)
☐ Pre-Existing DM with Pregnancy (ICD-10: O24.01)

**Indicate one or more reasons for referral:**
☐ Newly diagnosed ☐ Recurrent elevated blood glucose levels
☐ Recurrent Hypoglycemia ☐ Change in DM treatment regimen
☐ High risk due to Diabetes Complications ☐ Follow up/refresher education

**Indicate Education Type Below:**

☐ Individual Education (***Medicare will only cover individual education if one of the following disabilities/reasons is marked***) ☐ *Impaired mobility* ☐ *Impaired vision* ☐ *Impaired hearing* ☐ *Impaired dexterity* ☐ *Language barrier* ☐ *Impaired mental status/cognition* ☐ *Learning disability (please specify):* _____ ☐ *Other (please specify):* _____

☐ Group Comprehensive Self-Management Skills Class

☐ Insulin Instruction ☐ Self-blood glucose monitoring

☐ Management of Diabetes during Pregnancy/Gestational Diabetes Education

☐ Medical Nutrition Therapy (MNT) (**For Medicare Patients:***Can only be ordered by MD)*

### ☐ MNT/Nutrition Counseling

**Diagnosis Code(s):** _____

**Indicate Reason(s) for Referral:**
☐ Inappropriate weight gain/loss
☐ Diabetes
☐ Digestive Disorder
☐ Food allergies/intolerance
☐ Nutritional Anemia
☐ Eating/feeding Disorder
☐ Metabolic Disorders
☐ Metabolic Syndrome
☐ Pregnancy related condition
☐ Other:(Please Specify) _____

### ☐ Diabetes Prevention Program

*(To be eligible, Patient must not already have diagnosis of diabetes)*
**Diagnosis: ☐ Pre-diabetes (ICD-R73.09) ☐ Impaired Fasting Glucose (ICD-R73.01)**

**Hgb A1c:** _____ **FBG:** _____

**Provider Signature (Required):** _____ **Date:** _____
**Providers Name (Printed):** _____
**NPI:** _____ **Telephone:** _____

**I hereby certify that I am managing this beneficiary's medical condition and that the above prescribed training and education is a necessary part of management.** (*Required for Medicare patients*)