Providence Diabetes and Nutrition Center
3340 Providence Drive
A Tower, Fourth Floor, Suite A-453
Anchorage, AK 99508
Phone: 907.212.7980 Fax: 907.212.7981

1PORD

OUTPATIENT REFERRAL FOR MEDICAL NUTRITION THERAPY AND DIABETES EDUCATION

Fax completed form along with most recent lab results (ie: HbA1C, lipid panel, GTT etc.)
AND last chart note to 907-212-7981

Patient Name: _____ **DOB:** _____

Phone# (Home/Cell): _____ **(Work):** _____

Medical Diagnosis / Reason for Referral: *ICD-10 code(s) Required on Referral*

_____

_____

Treatment Plan / Service Requested

Please check the appropriate treatment plan item(s).

Nutrition Consults (ie: weight management, disordered eating, bariatric surgery evaluations, food allergy etc.)

- ☐ **Medical Nutrition Therapy:** Includes individual session(s) with the registered dietitian nutritionist

Diabetes Education Consults

- ☐ **Gestational Diabetes Education:** Includes glucose monitoring and meal planning instruction
- ☐ **Pre-Diabetes Education**
- ☐ **Diabetes Self-Management Education**:
  Incorporates both individual and group sessions based on patient needs. Sessions are taught by RN and RD educators. Instruction includes comprehensive diabetes education and medical nutrition therapy. The program is recognized by the American Diabetes Association.
- ☐ **Insulin Instruction:** (if new to insulin please instruct patient to bring supplies & insulin to first appointment)
  Type _____ Dose _____ Time of day _____
  Type _____ Dose _____ Time of day _____
  Is the patient to continue oral diabetes medications ☐ yes ☐ no ☐ N/A
  CDE may adjust insulin to meet blood sugar goal of _____
- ☐ **Insulin Pump Consult:** Required prior to pump training
- ☐ **Insulin Pump Training:** Includes 2 day training plus follow up
- ☐ **I Pro Evaluation:** (up to 6 day continuous glucose monitoring study)
- ☐ **Other**: _____

Physician/Provider **Signature:** _____ Date: _____

Printed Physician/Provider **Name:** _____ **Phone**: _____ **Fax:** _____