

Diabetes Self-Management Education & Medical Nutrition Therapy

Blanchard Valley Medical Associates

Fax Referral to 419-427-1795

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ Middle _____

Date of Birth: ___ / ___ / ___ Gender: Male ___ Female ___

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Other Contact Phone _____

DIABETES SELF-MANAGEMENT EDUCATION (DSME)

- Comprehensive Diabetes Self-Management Program
Includes 1:1 diabetes assessment, 1:1 MNT with RD, one-time 3 hour general education class and follow-up at 4 months and 12 months (recommended)
- Individual Diabetes Education (select all that apply)
- New Medication Training
Medication _____
Dose _____
- Insulin Training
Insulin _____
Dose _____
 Syringe Pen Vgo
- Glucometer Teaching Only
- Continuous Glucose Monitoring (Professional)
Reports to be faxed to your office
- Insulin Pump or Personal Continuous Glucose Monitor
Initial Discussion

MEDICAL NUTRITION THERAPY (MNT)

- Medical Nutrition Therapy (select all that apply)
- Diabetes (Nutrition Appointment Only)
- Gestational Diabetes
- Hyperlipidemia
- Hypertension
- Weight Management
- Insulin Resistance/PCOS
- Celiac Disease/Gluten Intolerance
- Other: _____

Please indicate any special considerations for your patient:

Check all special needs that apply:

- Vision Hearing Physical Cognitive Impairment
- Language Limitations Other _____

DIAGNOSIS:

- Type 1 DM, uncontrolled Type 1 DM, controlled
- Type 2 DM, uncontrolled Type 2 DM, controlled
- Gestational diabetes Other _____

DSME will include the following areas as required by the American Diabetes Association:

- Basic Pathophysiology of Diabetes
- Glucose Monitoring
- Medications
- Nutrition Management
- Physical Activity
- Problem Solving for Acute Complications
- Reducing the Risk of Chronic Complications
- Healthy Coping

PLEASE ATTACH THE FOLLOWING:

- Most Recent Progress Note
Please include Height, Weight and Blood Pressure
- Most Recent Labs
- Current Insurance Information
Please visit www.bvma.com for a full list of participating insurance plans

For questions regarding referral process, please call 419-427-1395

Provider's Printed Name: _____ Office Fax Number: _____

Provider's Signature: _____ Date: ___ / ___ / ___