DIABETES & NUTRITION SERVICES REFERRAL

❑ **Tacoma/Gig Harbor**
Phone: 253-403-1726
Fax: 253-459-6238

❑ **Puyallup**
Phone: 253-697-1356
Fax: 253-770-5175

❑ **Auburn/Covington**
Phone: 253-372-6996
Fax: 253-333-2607

Patient Name: _____ Date of Birth: _____

Address: _____

Preferred Phone: _____ Alternate Phone: _____

Insurance: _____ **Is patient expecting our call? Yes** _____ **No** _____

DIABETES **Diagnosis code (ICD-10):** _____
(Must be listed for referral to be valid)

Visit Type:
❑ Initial Evaluation/up to 13 hours ❑ Follow up evaluation/up to 4 hours. Insulin pump therapy training per protocol
❑ Type 1 ❑ Type 2 ❑ Gestational ❑ Unspecified
❑ New Diagnosis ❑ New to Insulin/Injectable – **Starting Dose**
Reason for Referral: _____
❑ Group Classes
Barriers to small group education: ❑ None ❑ English second language ❑ Hearing ❑ Vision ❑ Cognitive
❑ Other ***(CMS requires documentation)*** _____
Appointment Urgency: ❑ Non-urgent ❑ Urgent (patient needs to be seen within one week) ❑ Emergent
With Continuous Glucose Monitoring Service? ❑ YES ❑ No
Outpatient visit: ❑ Individual ❑ Group ❑ Both

Consult to Include:
❑ Diabetes monitoring
❑ Nutritional counseling
❑ Goal setting & problem solving
❑ Physical activity and exercise
❑ Review of Diabetes Medication
❑ Insulin Pump Education
❑ Professional Continuous Glucose Monitor
❑ Prevention of complications
❑ Psychological adjustments
❑ Other: _____

❑ Medication management per protocol
- ❑ Insulin adjustment by Diabetes Educator
- ❑ Comprehensive med management by Pharmacist

MEDICAL NUTRITION THERAPY **Diagnosis code (ICD-10):** _____
(Must be listed for referral to be valid)

* *Please confirm the specific diagnosis code listed above is covered under the patient's Nutrition Counseling benefit.*
* *PLEASE NOTE: Tacoma and South King County's scope of service for Medical Nutrition is only Diabetes, Pre-Diabetes, Cholesterol, HTN, CKD (up to stage III) and Pre-Bariatric Surgery. All other diagnosis' (in addition to the above listed) may be referred to the Puyallup locations.*

Reason for Referral: _____

Provider Name: _____ **Date:** _____

Provider Signature: _____ **Phone:** _____ **Fax:** _____

Patient Identification

Name:

MRN#:

CSN#:

Age/Sex:

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MultiCare

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