

DIABETES & NUTRITION SERVICES REFERRAL

Tacoma/Gig Harbor
Phone: 253-403-1726
Fax: 253-403-1722

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 Initial Evaluation/up to 13 hours Follow up evaluation/up to 4 hours. Insulin pump therapy training per protocol

Type: 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 Diabetes monitoring Insulin Pump Education
to Nutritional counseling Professional Continuous Glucose Monitor

Include: Goal setting & problem solving Prevention of complications

Physical activity and exercise Psychological adjustments

Review of Diabetes Medication 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 and Gender: _____

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MultiCare 



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