Please Fax Completed Forms and Additional Requested Information to 662-625-3024

Diabetes Solutions

Diabetes Self-Management Education Training and Support Services (DSMT)
and Medical Nutrition Therapy (MNT)

Referral Order Form

Patient's Last Name | First Name | Middle Name

Date of Birth _____/_____/_____ | Gender: ☐ Male ☐ Female ☐ Other

Ethnicity: _____ | Language: _____

Address | City | State | Zip Code

Phone | Alternate Phone | Email

Diagnosis

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Pre-Diabetes

☐ Gestational Diabetes ☐ PCOS ☐ Other_____

What **year** was the patient diagnosed with the condition that warrants referral? _____

A1c _____ Date of A1c: _____/_____/_____ Current Weight: _____ BMI _____

Please check type of service(s) and number of hours requested (DSMT max is 10 hours, MNT max is 3)

☐ DSMT 10 or ___ hours ☐ MNT 3 or ___ hours ☐ Both MNT and DSMT at max hours

Additional Requested Information

Along with this form, please include the following information when you fax us patient referrals:

1. Recent Labs (CMP, CBC etc.)
2. Other Medical Diagnoses
3. Current Medications
4. Insurance Information

I certify that I am the provider treating this patient and that DSMT and/or MNT is needed to provide the beneficiary with skills and knowledge to help self-manage and improve their condition.

Signature: _____ Date _____/_____/_____

Print Name: _____

Phone #: _____

Fax #: _____

Email: _____

Group Practice Name: _____

These services are offered through the
JAMES C. KENNEDY
Wellness Center