Stony Brook Medicine

Name_____
DOB _____
Phone_____
Insurance/ID number_____

Please complete EVERY section of this form.
Have patient bring this form to visit, and fax it to 631-444-4267
Patient can NOT be seen without fully completed form.

PHYSICIAN REFERRAL FORM
Stony Brook Medicine Diabetes Education

Diabetes Diagnosis:

☐ Type 1, no complications= E10.9 ☐ Type 1, w/hyperglycemia= E10.65
☐ Type 2, no complications= E11.9 ☐ Type 2, w/hyperglycemia= E11.65
☐ Gestational Diabetes= 024.429 ☐ Pre-Existing DM with Pregnancy= 024.319 ☐ Pre-diabetes= R73.03

Indicate one or more reason for referral:

☐ New diagnosis ☐ Change in DM treatment regimen
☐ Recurrent elevated blood glucose levels ☐ Recurrent Hypoglycemia
☐ High risk due to Diabetes Complications/Co-morbid conditions:
☐ Retinopathy ☐ Neuropathy ☐ Nephropathy ☐ Gastroparesis ☐ Hyperlipidemia
☐ Hypertension ☐ Cardiovascular disease ☐ other _____

Education Referral Needed for: Comprehensive Diabetes Self-Management Education/Support (DSMES)-
Medicare: 10 hours initial DSMES in 12-month period, plus 2 hours follow-up DSMES annually.

☐ Initial DSMES (group or individual) (G0109 or G0108)– 10 hrs/ all 10 contents
☐ Follow-up (individual) DSMES (1:1 RD, CDE or RN, CDE) (G0108)- 2 hrs./year
☐ Initial Medical Nutrition Therapy (individual w/RD, CDE) (97802)- 3 hrs. 1st year
☐ Follow up Medical Nutrition Therapy (individual w/RD, CDE) (97803)- 2 hrs./year

*** DSMES Content**

☐ **All ten topics/content areas**
☐Diabetes as disease process ☐Monitoring diabetes ☐Psychological adjustment ☐Physical activity
☐Nutritional management ☐Goal setting, problem solving ☐Medications
☐Acute complications- Prev. detection and treatment ☐Chronic complications- Prev. detection and treatment
☐Preconception/pregnancy- Management or gestational

Specific Topics and Hours if needs vary from above:_____

Indicate any existing barriers to group training requiring individual education:

☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing ☐ Impaired dexterity ☐ Language barrier ☐ Eating disorder
☐ Impaired mental status/cognition ☐ Learning disability ☐ 1:1 Insulin Training ☐ OTHER (please specify):_____

Current Treatment:

☐ Diet & Exercise ☐ Oral Agents ☐ Insulin

***DSME can be ordered by an MD, DO or mid-level provider managing the patient's diabetes.**
MNT can *only* be ordered by MD.

I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management.

Physicians' Signature: (Required) _____ **Date**_____

Physician's Name (Printed): _____ **NPI (Required):**_____ **Date**_____