LOURDES | Diabetes Program

Patient Referral Education

PLEASE FAX TO 215-283-1919

PATIENT

Name: _____ **Date of Birth:** _____

Phone (M): _____ (H): _____ (W): _____

Email Address: _____

- ❑ **E11.9** Type 2 diabetes without complications
- ❑ **E11.65** Type 2 diabetes with hyperglycemia
- ❑ **Other:** _____
- ❑ **E10.9** Type 1 diabetes without complications
- ❑ **E10.65** Type 1 diabetes with hyperglycemia
- ❑ **O24.419** Gestational diabetes in pregnancy

Please provide most recent HbA1c or FPG, if available, or most recent lab results.

HbA1c: **Result:** _____ **Date:** _____

Fasting Plasma Glucose (FPG): **Result:** _____ **Date:** _____

DSMT & MNT

❑ **COMPREHENSIVE DIABETES SELF MANAGEMENT PROGRAM (Includes DSME & MNT):**

Diabetes Self Management Education/DSME (10 hours):

- Individualized assessment
- Overview of the disease process
- Medication Management
- Nutrition
- Monitoring blood glucose, ketones and use of results to improve control
- Prevention, detection and treatment of complications
- Physical activity
- Psychosocial adjustment
- Goal setting & problem solving in daily living
- Diabetes Self-Management Support Planning

Medical Nutrition Therapy/MNT (2-6 hours)

- Personalized nutrition and diet plans
- Group and One-on-one Programs

Alternative to Comprehensive Program :

❑ DSME - Only (10 Hours) ❑ MNT - Only (2-6 Hour)

Location:

- ❑ Camden: Our Lady of Lourdes Medical Center
- ❑ Willingoro: Lourdes Medical Center of Burlington County
- ❑ Cherry Hill: LourdesCare at Cherry Hill
- ❑ Sewell: Margaret E. Heggan Library

Special Needs (if applicable):

- ❑ English as a second language ❑ Spanish ❑ Other: _____
- ❑ Group Learning Barriers
  - ❑ Non-ambulatory ❑ Vision ❑ Hearing ❑ Cognitive issue

OTHER SERVICES

- ❑ **DIABETES SELF MANAGEMENT REFRESHER PROGRAM (2 - 6 hour)**
- ❑ **INSULIN INITIATION (2-6 Hours)**
- ❑ **GESTATIONAL DIABETES PROGRAM (2-6 Hours)**

I certify that I am managing the beneficiary's diabetic condition and that the services described above are medically necessary under a comprehensive plan of care related to the beneficiary's diabetic condition to ensure therapy compliance and to help manage the beneficiary's diabetes.

Physician's Name (printed): _____ **NPI:** _____

Physician's Signature: _____ **Date:** _____

Phone number: _____ **Fax number:** _____

Lourdes Diabetes Program
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