Saint Francis Medical Center
OUTPATIENT SERVICES REFERRAL FORM
Diabetes Education

Name: _____ Date of Birth: ____/____/____

Primary Phone # _____

Insurance: ☐ Medicare ☐ Medicaid ☐ Other _____

Ordering Physician: _____

☐ Interpreter Needed: Language: _____

Certificate of Medical Necessity for Diabetes Self-Management Training

1. Services Requested:

☐ Diabetes Self-Management and Medical Nutrition Therapy
Diabetes Educator, RN, CDE, (DSMT) up to 10 hours (can include class)
& Registered Dietitian, (MNT) up to 3 hours

☐ Diabetes Self-Management Only (DSMT)
Diabetes Educator, RN, CDE, up to 10 hours

☐ Medical Nutrition Therapy Only (MNT)
Registered Dietitian, up to 3 hours

2. Diagnosis:

☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Pre-Diabetes (probable non-covered service)

3. Reason for Training:

☐ New Onset Diabetes -- Diagnosed within last 12 months/fasting BS≥ 126 mg on 2 occasions

☐ Recurrent -- Elevated fasting or random blood glucose levels are elevated

Hemoglobin A1C _____ result and date _____

☐ Change in Condition/treatment regimen:

☐ Initiating oral diabetes medication: Name & dosage _____

☐ Insulin Start RX: Type: _____

Dose: _____

Time: _____

☐ Other _____

4. Monitoring:

Is patient currently monitoring Blood glucose? ☐ Yes ☐ No

Physician Signature: _____ **Date:** _____ **Time:** _____

CATHOLIC HEALTH INITIATIVES
Saint Francis Medical Center
Well beyond healthcare.℠
2620 West Faidley Avenue
Grand Island, NE 68803

Saint Francis Medical Center Use Only
Account Number: F_____
Unit Number: H_____