Memorial Hospital OF SWEETWATER COUNTY

Medical Nutrition Therapy & Diabetes Self-Management Education and Support

Referral and Primary Care Provider Form

Patient Sticker

Patient Information

Name: _____ Date of Birth: _____ Primary Care Provider: _____

Address: _____ Phone: _____

Medical Information

Diagnosis: _____ Height: _____ Weight: _____

Medical History: _____

Medications: _____

Special Considerations: ☐ Visual ☐ Hearing ☐ Language ☐ Physical Disabilities

Lab Data: *Please fill in pertinent data below or attach lab reports.* ☐ Additional labs attached

A1c _____ Chol _____ Other _____

EDUCATION PLAN

Please [√] desired plan of care. *Education provided will be based on patient's needs, preferences and readiness.*

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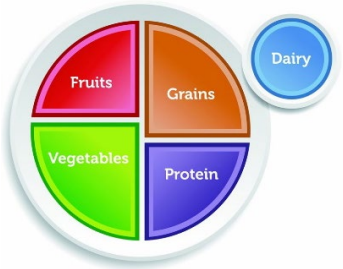


Medical Nutrition Therapy (MNT)

Defined as evidence-based application of the nutrition care process provided by the RDN

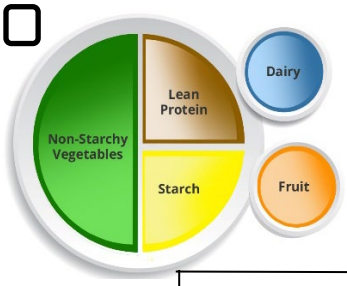
Please Fax to Outpatient Nutrition Clinical Services

Fax: 307-352-5324
Phone: 307-212-7781, 307-352-8528

MNT services:

- General nutrition
- Weight loss
- Weight gain
- Diabetes
- Healthy heart
- Sodium restriction
- Renal diet
- Food allergies
- _____
- _____
- _____
- _____

☐



Diabetes Self-Management Education and Support (DSMES)

Defined as the ongoing process of facilitating the knowledge, skill and ability necessary for diabetes self-care provided by RDN & RN

Please attach copy of insurance card and fax to Sweetwater County Community Nursing Services

Fax: 307-922-5496
Phone: 307-922-5390

DSMES Includes:

- DM pathophysiology and treatment options
- Healthy eating
- Physical activity
- Medication usage
- Monitoring and using patient-generalized health data
- Preventing, detecting, and treating acute and chronic complications
- Healthy coping with psychosocial issues and concerns
- Problem solving

_____ _____ _____ _____

Print Provider Name | Provider Signature | Date | Time

For Medicare Participants:** ***I hereby certify that I am managing this beneficiary's Diabetes condition and the above prescribed training as a necessary part of management.

***Primary Care Provider (PCP)** - **MUST be hand signed**: Medicare will not accept stamped signature.

_____ _____ _____ _____

Print PCP name | PCP Signature | Date | Time