CHESAPEAKE REGIONAL HEALTHCARE
LIFESTYLE & WELLNESS

American Diabetes Association. *The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education.

FAX TO: (757) 312-6271 CRH Outpatient Scheduling

Diabetes & Nutrition Education Prescription

Date _____

Patient Name: _____ DOB _____
Home Phone # _____ Cell# _____ Work # _____

DIAGNOSIS: (check all that apply)

☐ Type 2 Diabetes Controlled (E11.9)	☐ Prediabetes (R73.03)
☐ Type 2 Diabetes Uncontrolled/Hyperglycemia (E11.65)	☐ Hyperlipidemia (E78.5)
☐ Type 2 Diabetes Uncontrolled/Hypoglycemia (E11.649)	☐ Metabolic Syndrome (E88.81)
☐ Type 1 Diabetes Controlled (E10.9)	☐ Severe Obesity BMI ≥ 40 (E66.01)
☐ Type 1 Diabetes Uncontrolled/Hyperglycemia (E10.65)	☐ Obesity BMI 30 to 39.9 (E66.9)
☐ Type 1 Diabetes Uncontrolled/Hypoglycemia (E10.649)	☐ GI Dx (with ICD10 Code):_____
☐ Gestational Diabetes (O24.4)	☐ Other (with ICD10 Code):_____

SUPPORTING LABS (or attach with referral)

FBG	A1C	Total Chol.	LDL Chol.	HDL Chol.	Triglycerides	UACR

I am referring this patient for:

☐ **Complete Diabetes Program (***Includes 2 individual appointments: 1 with a Diabetes Educator and 1 with a Registered Dietitian, and 3 group classes - approximately 2 hours each – day and evening classes available).*

☐ **Diabetes Educator Consult and Diabetes Nutrition Consult** (*Includes 2 individual appointments: 1 with a Diabetes Educator and 1 with a Registered Dietitian)*

☐ **Nutrition Counseling/Medical Nutrition Therapy** (*Individual counseling with a Registered Dietitian.)*
If referring for a diagnosis other than those listed above, please include diagnosis and ICD-10 code above and include comments below.

☐ **Gestational Diabetes Consult/Class (***Includes nutrition management and self-glucose monitoring*)

☐ **Comments:** _____
_____
_____
_____

For Medicare Patients only:

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

☐ **This patient has special needs requiring only individual (1 on 1) education (please check any that apply):**
☐ **Vision** ☐ **Cognitive Impairment** ☐ **Hearing** ☐ **Language** ☐ **Other _____**

Print Name of Referring Physician/Provider_____Phone_____
Group Name and Address_____
Physician's/Provider's Signature _____Date _____

If you have any questions, please call the Lifestyle Center at (757) 312-6132.