UPMC LIFE CHANGING MEDICINE

UPMC Western Maryland Center for Clinical Resources Provider Referral Form

Patient's Name_____ **DOB**_____ **Primary Care Provider** _____

Patients Address_____ **Phone** _____

Health Insurance (please attach a copy) _____ **Ht:** _____ **Wt:**_____

Referred for the following services: Please send test results supporting diagnosis

Indicate any needs requiring special accommodations:	☐ Vision ☐ Hearing ☐ Physical _____	☐ Cognitive Impairment ☐ Low Literacy ☐ Behavioral Health	☐ Language Limitations ☐ Other _____

☐ **Diabetes Care Services**
Includes individual NP, CDE and Dietitian Counseling

See below for group education

☐ **Diabetes Education/DSMES**
Group Education
Medicare coverage: 10 hours initial DSME in 12-month period and 2 hours follow-up in following years. New referral required for follow up hours.

DSME can be ordered by an MD, DO, CRNP or PA-C managing the patient's diabetes.

The **Certified Diabetes Educator**® (**CDE**®) possesses comprehensive knowledge of and experience in **diabetes** management. The **CDE**® educates and supports people with **diabetes** so they may understand and manage their condition.

Diabetes Self-Management Education/ Support (DSMES) & nutrition counseling are complementary services to improve diabetes care. Both services can be ordered to help improve outcomes.

COMPLETE ALL SECTIONS

Diabetes Diagnosis:
☐ Type 1, uncontrolled –E10.65
☐ Type 1, controlled –E10.9
☐ Type 2, controlled –E11.9
☐ Type 2, uncontrolled –E11.65
☐ Gestational DM, diet controlled –O24.410
☐ Pre-existing DM, type 1, in pregnancy-024.01
☐ Pre-existing DM, type 2, in pregnancy- O24.11
☐ Other_____

Current Treatment:
☐ Diet & Exercise
☐ Oral agents
☐ Insulin _____

Indicate one or more reason for referral:
☐ Newly diagnosed
☐ Recurrent hypoglycemia
☐ Recurrent elevated blood glucose levels
☐ Change in diabetes treatment regimen
☐ Other_____

☐ ***Group*** Comprehensive Self –Management Education* (allowable time based on insurance benefit) unless otherwise noted._____hours

☐ Follow-up ***Group*** DSMES up to 2 hours unless otherwise noted._____hours.

DSMES Content Includes*: Monitoring, Disease Process, Psychological, Physical Activity, Nutrition, Medications, Prevent/ Detect /Treat Acute Complications, Goal Setting/Problem Solving.*

✓ POC HbA1c at 1st visit and PRN

Special needs requiring *individual* DSMES:
Circle all needs that require special accommodations above and these diabetes specific needs if applicable
1:1 Insulin Training Insulin Pump
Continuous Glucose Monitor Medication review
Other_____

Diabetes Complication/Comorbidities:
Circle all that apply
Retinopathy Cardiovascular Disease
Nephropathy Hypertension
Neuropathy Hyperlipidemia
Gastroparesis

☐ **Nutrition Counseling** ***Dietitian only***	☐ Diabetes ☐ Heart Failure	☐ COPD ☐ Other:_____

☐ **Heart Failure Services Check Indications** ***Includes medication titration and IV diuretic administration as indicated by patient presentation.***	☐ NYHA class II-IV symptoms ☐ Documented LVEF of <45% ☐ Left ventricular systolic dysfunction (LVSD) ☐ LVSD class II or worse, or class I with recent (within 60 days) hospitalization for volume overload	☐ Right sided heart failure ☐ Biventricular pacer placement due to cardiomyopathy ☐ ICD placement due to cardiomyopathy **For patients with none of the above additional criteria:** ☐ Refractory volume overload post-cardiothoracic surgery ☐ Readmission for heart failure <30 days following a heart failure admission

☐ **Sepsis & Sepsis Prevention Clinic**	☐ Sepsis Prevention & Education (high risk)	☐ Past Sepsis Admission w/in 6 months	☐ Infection Source:

☐ **COPD Services** ☐ CRNP and Respiratory Therapist ☐ Respiratory Therapist only	☐ Asthma ☐ Chronic Bronchitis ☐ Emphysema	☐ Pulmonary HTN ☐ Restrictive Lung Disease ☐ Occupational Lung Disease	☐ Thoracic Surgery ☐ Obesity/sleep apnea ☐ Other: _____

☐ **Medication Therapy Management (MTM)**	☐ Non-adherence	☐ Recent Transition of Care	☐ Multiple chronic disease states and/or medications

Referring Provider:_____/_____ **Date:**_____

PRINT **SIGNATURE**

Fax referral to: 240-964-8687 ***For questions, call: 240-964-8787***