Sparrow

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Sparrow Diabetes and Endocrinology Services Referral Form

All fields are required for insurance compliance

Date: **Fax: 517-364-8088**

Name: _____DOB:_____ Race: _____

Address: _____City:_____Zip:_____

Home Phone: _____Cell:_____

Primary Insurance: _____Contract:_____Group:_____

Secondary Insurance: _____Contract:_____Group:_____

Services Requested (select all that apply):

- ☐ **Appt with Endocrinologist**
- ☐ **Diabetes Education** based upon assessment of patient need. **To include MNT if needed.**
- ☐ **Medical Nutrition Therapy (MNT)** up to 6 hours in one year (up to 3 hours for Medicare patients in initial year and 2 hours in follow-up years) unless otherwise specified (optional) :_____
  Specify other dietary restrictions: _____
- ☐ **Gestational Diabetes Education**
- ☐ **Insulin Instruction** (must include medication, dosing, frequency, titration) _____

Reason for Education Referral:

☐ New Diagnosis date:_____ ☐ Medication changes

☐ At risk for complications ☐ New Medicare/Medicaid

☐ Uncontrolled

Diagnosis:

- ☐ Type 1 Diabetes (250.01)
- ☐ Type 2 Diabetes (250.00)
- ☐ Pre-diabetes **MNT only**
- ☐ Gestational diabetes
- ☐ Thyroid nodule/goiter
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Adrenal insufficiency
- ☐ Pituitary adenoma
- ☐ Hypogonadism
- ☐ Parathyroid disorders
- ☐ Other:

Medicare and Medicaid requirement for diabetes education

Medicare/Medicaid patients will receive up to 10 hours in the initial year (**once in a lifetime benefit**) and up to 2 hours in follow-up years unless otherwise specified (optional):_____

Diabetes education will be provided to patients with Medicare/Medicaid in **group classes** in initial year (except for up to one hour individual training) unless the below is completed:

Individual education is needed due to:

- ☐ Vision/Hearing impairment
- ☐ Physical limitations
- ☐ Language barrier (specify language) _____
- ☐ Low literacy
- ☐ Cognitive impairment
- ☐ Additional insulin training
- ☐ Other_____

Content areas to be taught: All areas as appropriate will be taught unless otherwise specified:_____

Labs:

A1C_____ FBG _____ _____

GTT_____ other_____

Referring physician name:_____

Address:_____City:_____ Zip:_____

Phone:_____Fax:_____

Physician Signature (required):_____Date:_____