**REFERRAL**

**Patient Name: Date of Birth:**

**Patient Phone Number(s):**

**Referring Provider: Phone Number:**

**Diagnosis Code (ICD-10):**

**Please indicate what services you are referring your patient for (You may select more than 1 box):**

* **Consultation with Endocrinologist Maria Rodebaugh, MD, FACE & other services needed.**
* **Diabetes Self-Management Education and/or Medical Nutrition Therapy**
  + Patient will be scheduled for an initial assessment with an RD, CDE for an assessment of their baseline diabetes self-management knowledge and skills or initial MNT assessment. The RD, CDE will negotiate an individualized education plan with your patient and a ***Diabetes Self-Management Education Order Sheet will be* *faxed to you for your approval or modification and signature after the initial assessment.***
* **Gestational Diabetes Initial Education Class to learn about gestational diabetes, blood sugar testing and diet modifications and consultation with Provider**
* **ReeVue Metabolic Testing**
  + Patient will be scheduled with a Certified Diabetes Educator to show precisely how many calories are burned in a day. Once completed the patient will be given their target caloric zones.

**Please FAX this form signed and all the available listed below to:**

**(208) 625-5501**

* **Current Labs**
* **Last Chart Note**
* **Current Medication List**
* **Demographics**
* **COPY of Insurance Cards**

**Provider Signature: Date: Time (REQUIRED):**