The Hospital of Central Connecticut
Center for Metabolic Health

Orders/Referral for New Patient Appointment

Patient Name: ____Date of Birth: ________ Gender: ☐ Male ☐ Female
Address: ____
Telephone # (Day):_____________ (cell): _______________Insurance carrier: ___________________________
Language: ☐English ☐Spanish ☐Other___________________

☐ Newly DX: ________ Date: __________ *Diagnosis:* ___________ Years w/DIA___________

☐ Type 1 (250.01) ☐ Type 1 Uncontrolled (250.03) ☐ Impaired Fasting Glucose (790.21) ☐ Pre-diabetes (790.29)

☐ Type 2 (250.00) ☐ Type 2 Uncontrolled (250.02) ☐ Impaired Glucose Tolerance (790.22)

☐ Gestational Diabetes (648.83) ☐ Diabetes w/Pregnancy (648.03) ☐ Other______________________

Reason for Consultation

☐ Endocrinologist
- ☐ Routine Consult (2-4 weeks) ☐ Important (1-2 weeks) ☐ Urgent (1-3 days)
- ☐ Diabetes ☐Thyroid ☐ Endocrine ☐ Osteoporosis ☐ Lipid Disorder ☐ Hormone Therapy

Education Referral

☐ Initial Comprehensive Diabetes Self-Management Training (DSMT)-10hrs and all 9 topics

☐ Specific Topics and Hours if needs vary from above: select below and number of hours______________________
- ☐ Disease Process ☐ Nutrition Management ☐ Physical Activity ☐ Safe use of medications ☐ Blood glucose monitoring
- ☐ Acute complications ☐ Chronic complications ☐ Psychosocial issues ☐ Strategies to promote health and behavior change

☐ DSMT: Follow up- 2hrs

Indicate one or more reasons for referral:

☐ Recurrent elevated blood glucose levels

☐ Recurrent Hypoglycemia

☐ Change in DM treatment regimen

☐ High risk due to Diabetes Complications/Co-morbid conditions:____

☐ 1:1 Injectable medication training

Indicate any barriers to group learning or additional insulin training requiring 1:1 education:

☐ Language (other than English): ______________ ☐ Impaired mobility ☐ Impaired mental status/cognition

☐ Impaired Vision/Hearing ☐ Learning disability ☐ other: ____

Medical Nutrition Therapy (MNT) Referral

☐ Initial MNT – 3hrs
☐ MNT Follow-up- 2hrs
☐ Specific Topics and Hours if needs vary from above: _____________________________

Note: In order for Diabetes Self-Management Training (DSMT) and MNT to be reimbursed by Medicare (and many other insurers), the physician/provider must provide the following information:

IMPORTANT: Please Send Recent Office Notes & Labs.	Result	Date
Fasting Glucose result		
Second fasting Glucose		
A1c (<6.5)		
Microalbumin (<20)		
LDL cholesterol (<100)		
Blood pressure (<130/80)		
Other (GTT results for GDM)		

I certify that DSMT services are needed under a comprehensive plan for this patient's diabetes care for the reason(s) listed above.
I understand that patient reports will be sent at the end of the class series and after subsequent follow-up visits.

Referring Provider: ____________________________________
Phone#:________________ Fax#:_______________

Provider Signature: ____________________________________ Date: ______________________

Please check patient's preferred location to attend Diabetes program:

☐ New Britain ☐ 98 Main St, Southington ☐ 11 South St, Farmington *Office: 860.224-5512 or 5363 Fax: 860.224.5967*