FAU COMMUNITY HEALTH CENTER

Christine E. Lynn College of Nursing
Florida Atlantic University

Community Health Center
1650 Osceola Drive
West Palm Beach, FL 33409
Tel: (561) 803-8880
Fax: (561) 803-8899
www.nursing.fau.edu

Referring Institution/Provider: _____

Patient's Name: _____ Date of Birth: _____

Home Tel: _____ Cell Phone: _____

Insurance #1: _____ Insurance #2: _____

Is Authorization Needed? ❑ YES ❑ NO If Needed: Auth#: _____

Please send recent labs for patient eligibility and outcome monitoring

DIAGNOSIS

- ❑ Type 1 uncontrolled
- ❑ Type 1 controlled
- ❑ Type 2 uncontrolled
- ❑ Type 2 controlled
- ❑ Gestational
- ❑ New Onset
- ❑ Pre-diabetes
- ❑ Other _____

Complications/Comorbidities

Please check all that apply

- ❑ E11.9 diabetes w/o complications
- ❑ E13.10 diabetes w/cetoacidosis
- ❑ E11.01 diabetes w/hyperosmolarity
- ❑ E11.641 diabetes w/other coma
- ❑ E11.21 diabetes w/renal manifestations
- ❑ E11.311 diabetes w/ophthalmic manifestation
- ❑ E11.40 diabetes w/neurological manifestations
- ❑ E11.51 diabetes w/peripheral circulatory disorders
- ❑ E11.618 diabetes w/other specified manifestations
- ❑ E11.8 diabetes w/unspecified manifestations
- ❑ Z8632 Gestational diabetes
- ❑ N18.9 Chronic Renal Failure (non-dialysis)
- Z48.2 Status post renal transplant

DSMT CONTENT

- ❑ All 10 content areas, as appropriate
- ❑ F/up as appropriate
- ❑ Monitoring Diabetes
- ❑ Diabetes as disease process
- ❑ Psychological adjustment
- ❑ Physical activity
- ❑ Nutritional management
- ❑ Medications
- ❑ Goal setting, problem solving
- ❑ Pump/Injectable Therapy
- ❑ Prevent, detect and treat acute complications
- ❑ Prevent, detect and treat chronic complications

Management:

- ❑ Preconception/pregnancy managment
- ❑ Gestational diabetes management
- ❑ Medication Adjustment/ Recommendation by ARNP & Pharmacist

Patients with special needs requiring individual DSMT

Please check all that apply

❑Vision ❑Hearing ❑Physcial ❑Cognitive ❑Telehealth

❑Language limitation ❑Other _____

NOTE to Primary Care Provider: MUST sign this referral and fax with recent labs, and check off diagnosis/complications

Provider's Signature: _____

Date: _____

Provider's Name (Printed): _____

NPI: _____

Case Manager/RN/Dietitian: _____

I understand that this form may be faxed by _____ to the FAU Community Health Center for the purpose of diabetes management services. I understand that this authorization will expire 1 year after I have signed this form and that I may revoke this authorization at any time. I have been informed that the party faxing this form will not received financial or in-kind compensatin in exchange for using or disclosing the health information described above.

_____

Signature of Patient/ Legal Guardian