

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

<p>Indicate any needs requiring special accommodations:</p>	<input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Physical _____	<input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Low Literacy <input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Language Limitations <input type="checkbox"/> Other _____
<p><input type="checkbox"/> Diabetes Care Services <i>Includes individual CDE* and Nutrition Counseling</i></p> <p align="center">See below for group education</p> <p><input type="checkbox"/> 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.</p> <p>DSME can be ordered by an MD, DO, CRNP or PA-C managing the patient's diabetes.</p> <p>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.</p> <p>Diabetes Self-Management Education/Support (DSMES) & nutrition counseling are complementary services to improve diabetes care. Both services can be ordered to help improve outcomes.</p>	<p align="center">COMPLETE ALL SECTIONS</p> <p>Diabetes Diagnosis: <input type="checkbox"/> Type 1, uncontrolled –E10.65 <input type="checkbox"/> Type 1, controlled –E10.9 <input type="checkbox"/> Type 2, controlled –E11.9 <input type="checkbox"/> Type 2, uncontrolled –E11.65 <input type="checkbox"/> Gestational DM, diet controlled –O24.410 <input type="checkbox"/> Pre-existing DM, type 1, in pregnancy-024.01 <input type="checkbox"/> Pre-existing DM, type 2, in pregnancy- O24.11 <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Group Comprehensive Self –Management Education* (allowable time based on insurance benefit) unless otherwise noted. _____ hours</p> <p><input type="checkbox"/> Follow-up Group DSMES up to 2 hours unless otherwise noted. _____ hours.</p> <p>Special needs requiring individual DSMES: <i>Circle all needs that require special accommodations above and these diabetes specific needs if applicable</i> 1:1 Insulin Training Insulin Pump Continuous Glucose Monitor Medication review Other _____</p> <p>Current Treatment: <input type="checkbox"/> Diet & Exercise <input type="checkbox"/> Oral agents <input type="checkbox"/> Insulin _____</p> <p>Indicate one or more reason for referral: <input type="checkbox"/> Newly diagnosed <input type="checkbox"/> Recurrent hypoglycemia <input type="checkbox"/> Recurrent elevated blood glucose levels <input type="checkbox"/> Change in diabetes treatment regimen <input type="checkbox"/> Other _____</p> <p>DSMES Content Includes: <i>Monitoring, Disease Process, Psychological, Physical Activity, Nutrition, Medications, Prevent/ Detect /Treat Acute Complications, Goal Setting/Problem Solving.</i></p> <p>Diabetes Complication/Comorbidities: <i>Circle all that apply</i> Retinopathy Cardiovascular Disease Nephropathy Hypertension Neuropathy Hyperlipidemia Gastroparesis</p>		
<p><input type="checkbox"/> Nutrition Counseling <i>Dietitian only</i></p>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure	<input type="checkbox"/> COPD <input type="checkbox"/> Other: _____	
<p><input type="checkbox"/> Heart Failure Services Check Indications</p> <p><i>Includes medication titration and IV diuretic administration as indicated by patient presentation.</i></p>	<input type="checkbox"/> NYHA class II-IV symptoms <input type="checkbox"/> Documented LVEF of <45% <input type="checkbox"/> Left ventricular systolic dysfunction (LVSD) <input type="checkbox"/> LVSD class II or worse, or class I with recent (within 60 days) hospitalization for volume overload	<input type="checkbox"/> Right sided heart failure <input type="checkbox"/> Biventricular pacer placement due to cardiomyopathy <input type="checkbox"/> ICD placement due to cardiomyopathy <p>For patients with none of the above additional criteria: <input type="checkbox"/> Refractory volume overload post-cardiothoracic surgery <input type="checkbox"/> Readmission for heart failure <30 days following a heart failure admission</p>	
<p><input type="checkbox"/> COPD Services <input type="checkbox"/> CRNP and Respiratory Therapist <input type="checkbox"/> Respiratory Therapist only</p>	<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Emphysema	<input type="checkbox"/> Pulmonary HTN <input type="checkbox"/> Restrictive Lung Disease <input type="checkbox"/> Occupational Lung Disease	<input type="checkbox"/> Thoracic Surgery <input type="checkbox"/> Obesity/sleep apnea <input type="checkbox"/> Other: _____
<p><input type="checkbox"/> Medication Therapy Management (MTM)</p>	<input type="checkbox"/> Non-adherence	<input type="checkbox"/> Recent Transition of Care	<input type="checkbox"/> Multiple chronic disease states and/or medications

Referring Provider: _____ / _____ Date: _____

PRINT
 Fax referral to: 240-964-8687

SIGNATURE
 For questions, call: 240-964-8787