UPMC LIFE CHANGING MEDICINE

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

<table>
<tr><td>Indicate any needs requiring special accommodations:</td><td colspan="2">☐ Vision
☐ Hearing
☐ Physical ____________
☐ Cognitive Impairment
☐ Low Literacy
☐ Behavioral Health
☐ Language Limitations
☐ Other _____________</td></tr>
<tr><td>☐ Diabetes Care Services
Includes individual NP, CDE and Dietitian Counseling

See below for group education

☐ Diabetes Education/DSMES
Group Education
<u>Medicare coverage</u>: 10 hours initial DSME in 12-month period and 2 hours follow-up in following years. New referral required for follow up hours.

DSME can be ordered by an MD, DO, CRNP or PA-C managing the patient's diabetes.

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.

Diabetes Self-Management Education/ Support (DSMES) & nutrition counseling are complementary services to improve diabetes care. Both services can be ordered to help improve outcomes.</td><td colspan="2">COMPLETE ALL SECTIONS
<u>Diabetes Diagnosis:</u>
☐ Type 1, uncontrolled –E10.65
☐ Type 1, controlled –E10.9
☐ Type 2, controlled –E11.9
☐ Type 2, uncontrolled –E11.65
☐ Gestational DM, diet controlled –O24.410
☐ Pre-existing DM, type 1, in pregnancy-024.01
☐ Pre-existing DM, type 2, in pregnancy- O24.11
☐ Other________

<u>Current Treatment:</u>
☐ Diet & Exercise
☐ Oral agents
☐ Insulin _______
<u>Indicate one or more reason for referral:</u>
☐ Newly diagnosed
☐ Recurrent hypoglycemia
☐ Recurrent elevated blood glucose levels
☐ Change in diabetes treatment regimen
☐ Other_______________________

☐ Group Comprehensive Self –Management Education* (allowable time based on insurance benefit) unless otherwise noted.__________hours

☐ Follow-up Group DSMES up to 2 hours unless otherwise noted.______hours.

DSMES Content Includes: Monitoring, Disease Process, Psychological, Physical Activity, Nutrition, Medications, Prevent/ Detect /Treat Acute Complications, Goal Setting/Problem Solving.

✓POC HbA1c at 1st visit and PRN

<u>Special needs requiring individual DSMES:</u>
Circle all needs that require special accommodations above and these diabetes specific needs if applicable
1:1 Insulin Training   Insulin Pump
Continuous Glucose Monitor Medication review
Other______________

<u>Diabetes Complication/Comorbidities:</u>
Circle all that apply
Retinopathy   Cardiovascular Disease
Nephropathy   Hypertension
Neuropathy   Hyperlipidemia
Gastroparesis</td></tr>
<tr><td>☐ Nutrition Counseling
Dietitian only</td><td colspan="2">☐ Diabetes
☐ Heart Failure
☐ COPD
☐ Other:____________________</td></tr>
<tr><td>☐ Heart Failure Services
Check Indications

Includes medication titration and IV diuretic administration as indicated by patient presentation.</td><td>☐ NYHA class II-IV symptoms
☐ Documented LVEF of <45%
☐ Left ventricular systolic dysfunction (LVSD)
☐ LVSD class II or worse, or class I with recent (within 60 days) hospitalization for volume overload</td><td>☐ Right sided heart failure
☐ Biventricular pacer placement due to cardiomyopathy
☐ ICD placement due to cardiomyopathy
For patients with none of the above additional criteria:
☐ Refractory volume overload post-cardiothoracic surgery
☐ Readmission for heart failure <30 days following a heart failure admission</td></tr>
<tr><td>☐ Sepsis & Sepsis Prevention Clinic</td><td colspan="2">☐ Sepsis Prevention & Education (high risk)
☐ Past Sepsis Admission w/in 6 months
☐ Infection Source:</td></tr>
<tr><td>☐ COPD Services
☐ CRNP and Respiratory Therapist
☐ Respiratory Therapist only</td><td colspan="2">☐ Asthma
☐ Chronic Bronchitis
☐ Emphysema
☐ Pulmonary HTN
☐ Restrictive Lung Disease
☐ Occupational Lung Disease
☐ Thoracic Surgery
☐ Obesity/sleep apnea
☐ Other: _____________</td></tr>
<tr><td>☐ Medication Therapy Management (MTM)</td><td colspan="2">☐ Non-adherence
☐ Recent Transition of Care
☐ Multiple chronic disease states and/or medications</td></tr>
</table>

Referring Provider:________________________________/____**Date:**____________

PRINT **SIGNATURE**

Fax referral to: 240-964-8687 ***For questions, call: 240-964-8787***