GET HEALTHY LIVE WELL

Outpatient Education Referral Form

805 Dixie Street – Carrollton, GA 30117
Telephone: 770.812.5954 Fax: 770.812.5776

TANNER HEALTH SYSTEM

We are pleased to provide same-day walk-in appointments at our location above.
Please send your patient to our office to be seen today!

Patient Name: _____ Date of Birth: ____/____/_____

Patient Phone: _____ Insurance: _____

Diagnosis (including ICD-10 code)

_____

*Special needs due to impairment of: ☐ vision ☐ hearing ☐ language ☐ reading ☐ other_____
Patients with special needs are eligible for 10 hours of individual 1 on 1 training

(please check appropriate boxes for service)

☐ Pre-Diabetes/Metabolic Syndrome

☐ Diabetes Self-Management Education

Current Diabetes Medication: ☐ Insulin regimen ☐ Oral agents ☐ Other injectables

☐ Gestational Diabetes: # weeks gestation: _____ Estimated Delivery Date: _____

☐ Medical Nutrition Therapy (MNT) – with Registered Dietitian

☐ Living Well with Chronic Disease

☐ Tobacco Cessation

☐ Get Healthy Kids

The following are MEDICARE criteria for DIABETES only services -must have occurred within the last 12 months; must have documentation of the labs before accepting the referral.

- Fasting blood sugar greater than or equal to 126 mg/dl on two different occasions (or)
- Two hour post-glucose challenge greater than or equal to 200 mg/dl on two different occasions (or)
- Random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes
- Change in Medical Condition, diagnosis or treatment i.e., chronic renal insufficiency and diabetes

Please fax this referral, along with relevant labs (blood glucose, A1c, lipids, creatinine, basic metabolic panel, or relevant physician notes) to 770.812.5776.

The American Diabetes Association Recognized Diabetes Patient Education Program / Medical Nutrition Therapy is integral to the care of my patient. The signature below certifies that I am managing the beneficiary's diabetes, renal condition or other specified condition and the training is needed to provide skills and knowledge to help manage this/these condition(s).

Physician's Signature: _____ Date: _____

Physician's Name: _____ Physician's Phone: _____

Physicians will receive updates after each visit. Thank you for your referral!