Sun Health™ WELLNESS

14719 W. Grand Avenue
Surprise, Arizona 85374
(623) 471-WELL (9355)

REFERRAL FORM

DIABETES SELF MANAGEMENT TRAINING (DSMT) & MEDICAL NUTRITION THERAPY (MNT)

PATIENT DATA

Name: ________________________________ Date of Birth: __________________ Phone: __________________

Insurance Type: ______________________________ ID#:______________

Does Patient have clearance to exercise? YES NO

DIAGNOSIS

Code	Description	Code	Description
E10.8	T1 with unspecified complications	N18.31	Chronic kidney disease, stage 3a
E10.9	T1 without complications	N18.32	Chronic kidney disease, stage 3b
E11.65	T2 with hyperglycemia	N18.4	Chronic kidney disease, stage 4
E11.69	T2 with other specified complications	N18.5	Chronic kidney disease, stage 5
E11.8	T2 with unspecified complications	OTHER	_______________________________
E11.9	T2 without complications		

SERVICES TO BE PERFORMED

**Please submit the most recent clinical notes and labs with the referral*

Initial 10-hour DSMT and Initial 3-hour MNT

Initial 10-hour DSMT

DSMT will be provided in a group setting unless a special need is identified, then can be in an individual format:

Cognitive Language Physical Disability Hearing Non-Ambulatory Vision

Other: ____

Initial 3-hour MNT

Annual 2-hour DSMT and 2-hour MNT

Annual 2-hour DSMT

Annual 2-hour MNT

Additional MNT ________ hours, due to ____

PROVIDER DATA

Name: ________________________________ Signature:______________________________Date: _______________

Phone: ________________________________ FAX: __________________________________ NPI:________________

PLEASE FAX COMPLETED FORM TO: (623) 213-8523