DEAP
Diabetes Education Accreditation Program
AADE American Association of Diabetes Educators

Adventist Health Castle
Wellness & Lifestyle Medicine

Wellness & Lifestyle Medicine Center
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REFERRAL FORM

Patient's Last Name:	Patient's First Name:
Date of Birth:_____ Gender: M / F	Phone:_____
Health Insurance Carrier: _____	Member ID number:_____

Diabetes Management - Please Send A Copy of H&P and All Current Lab Work

☐ Diabetes Medical Management and Education (99203-99205; 99213-99215)

Nurse practitioner and certified diabetic educator will work with the primary care/referring provider to manage diabetes through review and on-going monitoring of the following: blood glucose, food and activity log, lab results, anti-diabetic medication (dose adjustments, addition/discontinuation of diabetes medications). The patient may receive group education as needed.

Diagnosis: ☐ Prediabetes ☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Gestational diabetes

ICD-10 Code (required): Other

☐ Diabetes Education ONLY (G0108/G0109)

Education is taught by a certified diabetes educator based on the 7 AADE components: monitoring, being active, healthy eating, coping, problem solving, reducing risks and medication mechanism of action. A post-education note will be provided to the primary care provider/referring provider.

Diagnosis: ☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Gestational diabetes

ICD-10 Code (required): Other

Registered Dietitian Services - Nutrition Counseling / Medical Nutrition Therapy (MNT)

Please Send A Copy of H&P and All Current Lab Work

Diagnosis: ☐ Diabetes ☐ Chronic Renal Failure ☐ Hyperlipidemia ☐ Hypertension ☐ Obesity ☐ Other:_____ **ICD-10 Code (required):** Other _____

Tobacco Treatment Services (Free)- No Physician Signature Required

☐ Tobacco/Nicotine Treatment Counseling (Coaching and follow-up, by appointment).

Fitness Services Reason for referral: _____

☐ Group Exercise Classes $10/day, $40/mo, $100/qtr (various classes)
☐ Individual Fitness Training (coaching and follow-up, by appointment, $75/hr)

Physician Name:	Date:
Physician Signature:	Office Phone: Office Fax:

PRINT FORM ◯ EMAIL FORM ◯ CLEAR FORM ◯