YouCose Health

1-503-566-6067 | 503-847-9952 | youcosehealth.com

STEP 1 PATIENT INFORMATION

Patient's Name _____ **Date of birth:** _____

Email address: _____ **Phone number:** _____

STEP 2 REASON FOR REFERRAL

✓ ICD-10	DIABETES	✓ ICD-10	
☐ _ _ . _ _	Type 2 DM	☐ _ _ . _ _	Latent Autoimmune Diabetes in Adults (LADA)
☐ _ _ . _ _	Type 1 DM	☐ _ _ . _ _	Gestational Diabetes

✓ PATIENT-CENTERED DIABETES CARE SERVICES

Patients will receive an individualized comprehensive assessment & education around diabetes pathophysiology, nutrition, blood glucose monitoring, etc.

- ☐ Insulin instructions (Injection instructions, sight instruction, insulin-carb ratios, etc)
- ☐ Blood glucose meter instructions (initiate/educate/recommend based on insurance coverage)
- ☐ Diabetes medication instructions (SLGT-2, GLP-1, etc)
- ☐ Continuous Glucose Monitor (Placement/Interpret reports)
- ☐ Insulin pump therapy
- ☐ Six-week diabetes workshop

✓ ICD-10 ENDOCRINE, NUTRITIONAL & METABOLIC DISEASES

☑ Z71 . 3 _	Nutrition counseling and surveillance	☐	0358T, Whole Body Composition Analysis (% lean/fat body mass) via BIA
☐ _ _ . _ _	Prediabetes/Impared fasting glucose	☐ _ _ . _ _	Metabolic Syndrome (≥3 of these conditions: abd obesity, HTN, ↑ TG, ↑ BG, ↓ HDL)
☐ _ _ . _ _	Reactive Hypoglycemia	☐	Weight Management (for weight gain/ for weight loss)

✓ ICD-10	CARDIOVASCULAR HEALTH	✓ ICD-10	
☐ _ _ . _ _	Hypertension	☐ _ _ . _ _	Hypertriglyceridemia/Hyperlipidemia
☐ _ _ . _ _	Heart Disease	☐ _ _ . _ _	Other _____

✓ ICD-10	KIDNEY HEALTH		
☐ _ _ . _ _	Chronic Kidney Disease (specific stage)	☐ _ _ . _ _	Other _____

✓ ICD-10 SPECIAL DIETS

☐ Intermittent Fasting (5-Day Fasting Mimicking diet, 5:2 diet), Time-Restrictive Eating (6–12 hours a day), vegan, vegetarian, Mediterranean, ketogenic, low/very-low-carbohydrate diet, low FODMAP diet, 5-R Protocol, and etc.

STEP 3 PLEASE INCLUDE RECENT ORDERS OF LABS, RELEVENT CHART NOTES, INSURANCE, AND MEDICATION

***Provider signature:** _____ **Today's date:** _____

Provider name (print): _____ **Fax:** _____

Office coord. (print): _____ **Phone:** _____

☐ I give permission to the Certified Diabetes Care and Educator Specialist to adjust oral (for diabetes), injectables (for diabetes), and/or insulin adjustments medically aligned with the ADA Standards of Care and AACE.

*By signing this referral I hereby certify that I am managing this patients's condition and that the above prescribed training is a necessary part of management. I give permission to nutrition expert to provide nutrition visits as medically necessary.

Please attach a copy of pertinent Labs, Medical History, and Insurance. | PLEASE FAX TO YOUCOSE HEALTH AT: **1-503-566-6067**