Stacy L. Haumea Dr. BH, RDN, CDE
Ph 808.430.6735, Fax 808.756.9555, email: stacy.haumea@gmail.com

Referral for Medical Nutrition Therapy & Diabetes Education

Date:	Patient Name:
Phone:	Address:
Date of birth:	Insurance/Policy# (Attach a copy of card)

Please FAX this Referral to_____(808) 756-9555_____, including:

- **Last office visit note, last labs, active medication list**
- **Patient Demographics and medical insurance**

***As a specialist, I must have this form signed and received before scheduling an appointment.**

- **Please give or mail patient a copy of this referral for their appointment.**

► **DIAGNOSES** - Check **ALL that Apply For Reimbursement/Medical Necessity**

□ Diabetes Type 2	□ Obesity (BMI >30) □ Ped 6yr +	□ CKD
□ Diabetes Type 1	□ Hypertension	□ Pre/Post Bariatric surgery
□ Diabetes Gestational	□ Hyperlipidemia	□ Prenatal nutrition
□ Pre-existing DM with pregnancy	□ Eating Disorder (F50.__)	□
□ Other: ICD-10_____		

►**SERVICES TO BE PERFORMED – Both MNT & DSME apply so please check all that apply**

Medical Nutrition Therapy (MNT)		
□ Initial – 3 hours	□ 1:1	□ Group
□ Follow-up – 2 hrs	□ 1:1	□ Group
□ Additional #____ hours required; change in medical condition, treatment and/or diagnosis		

Diabetes Self Management Education (DSME)		
□ Initial – 10 hrs	□ 1:1	□ Group
□ Follow-up -	□ 1:1	□ Group
□ Additional #____ hours required; change in medical condition, treatment and/or diagnosis		

Diabetes Education: All topics taught unless only specific ones selected:
□ SMBG □ Nutrition □ Exercise □ Acute Complications □ Chronic Complications □ Medication
□ Pathophysiology □ Goals □ Problem-Solving □ Psychosocial Adjustment

Patient with special needs who requires individual (1:1) visits:
□ Vision/Speech/Hearing □ Physical □ Language □ Cognitive impairment (learning/processing)
□ Insulin training □ Continuous Glucose Monitor training □ Other:_____

► **Exercise/Activity Plan**
□ Released: May perform light / moderate / high intensity activity, ____minutes ___days/week
□ Not released:_____

►**PHYSICIAN DATA** NPI:_____
Print Name:_____ Signature:_____
Phone: _____ Fax:_____

The information requested above is Protected Health Information (PHI) and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.

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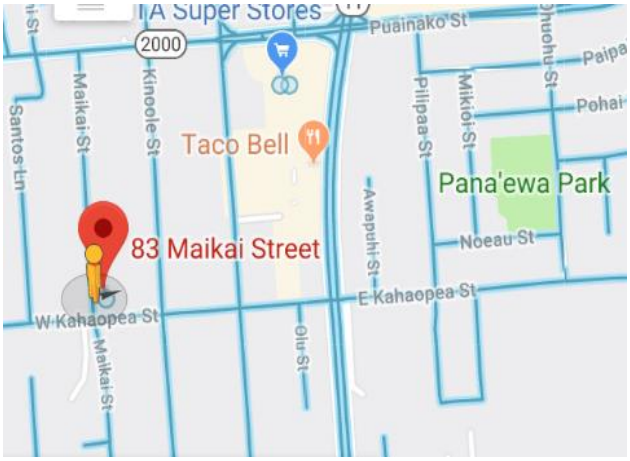
Appointment Details



___Stacy Haumea Dr. BH, Nutritionist, Diabetes Educator _____ IS CONVENIENTLY

LOCATED AT:_____83 Maika'i St., Hilo, HI_____

TO MAKE AN APPOINTMENT _MON/TUE/WED 8 AM – 5 PM__, CALL __(808) 430.6735_

FOR PATIENT USE:

MY APPOINTMENT DATE IS:_____ AT:_____ (TIME)

PLEASE CALL AT LEAST **24 HOURS** IN ADVANCE IF YOU NEED TO CANCEL THIS APPOINTMENT. WE WILL RE-SCHEDULE AS SOON AS POSSIBLE.

Bringing the following items to your visit will help your Nutritionist serve you better:

1) Medical insurance cards & Picture I.D.
2) Blood glucose meter or logbook with recent results, if you have one
3) Listing of all your prescription medications, with times taken and dose
4) Copy of your latest blood and/or urine tests, if you have it
5) A log of all foods and drinks consumed and approximate amounts, for 1-3 days prior to this first visit
6) A list of questions you would like answered during our visit

Mauli'Ola Medical, LLC
Phone (808) 430-6735 mauliolamedical@gmail.com Fax (808) 756-9555