Diabetes Education Program

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PHYSICIAN REFERRAL FORM

Patient's name: ______________________ **DOB:** ____________ **Phone #:** ______________________
Address:____
Health Insurance ____

Diabetes Diagnosis: ☐ Type1-controlled ☐ Type1-uncontrolled ☐ Type 2-controlled ☐ Type 2-uncontrolled
☐ Gestational ☐ Pre-Existing DM with Pregnancy ☐ Pre-diabetes

Current Treatment: ☐ Diet & Exercise ☐ Oral Agents: ________________________ ☐ Insulin __________

Indicate one or more reason for referral:
☐ Recurrent elevated blood glucose levels
☐ Recurrent Hypoglycemia
☐ Change in DM treatment regimen
☐ High risk due to Diabetes Complications/Co-morbid conditions: ☐ Retinopathy ☐ Neuropathy ☐ Nephropathy
☐ Gastroparesis ☐ Hyperlipidemia ☐ Hypertension ☐ Cardiovascular disease ☐ Other ________________

Recent Labs:
☐ **F**BG: ___________ Date: _____________
☐ HgbA1C: ________ Date: _____________
☐ Micro-albumin: _________ Date: _____________
☐ Total Cholesterol: ________ Date: _____________
☐ HDL: ___________ Date: _____________
☐ LDL: ___________ Date: _____________
☐ Triglycerides: ___________ Date: _____________

Education Needed:
☐ Comprehensive Self Management Skills (group)
☐ Comprehensive Self Management Skills (individual sessions)
☐ Insulin Instruction
☐ Basic Nutrition Management
☐ Medical Nutrition Therapy (MNT)
☐ Self blood glucose monitoring
☐ Management of Diabetes during Pregnancy/Gestational Diabetes Education

Indicate any existing barriers requiring customized education:
☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing ☐ Impaired mental status/cognition
☐ Impaired dexterity ☐ Language barrier ☐ Eating disorder
☐ Learning disability (please specify): ____
☐ Other (please specify): ____

☐ **I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management. (Medicare patients)**

Physicians' signature: (Required) ____________________________**Date:**________________
Physician's Name (Printed): ______________________**Phone #:**__________**Fax #:**____________