

Orange County Health Department Diabetes Self-Management Education Program Referral Process

Thank you for making a referral to the Orange County Diabetes Self-Management Education (DSME) Program. Your clients are important to us, and we want to ensure that they receive the appropriate care in a timely manner. Please review the following guidelines to make this process both efficient and effective.

- The medical provider should complete the Orange County DSME Program referral form. The referral form **must** include the following:
 - diabetes diagnosis
 - recent A1C test results
 - blood pressure reading
 - medical provider's signature
- Please fax the referral form to 919-644-3312. The Orange County Health Department is HIPAA compliant and referrals are received by a secure fax machine.
- DSME Program staff will call the client to schedule the initial appointment.
- If DSME Program staff are unable to reach the client after three attempts or the client declines services, staff will fax this information to the medical provider to complete the referral process. The medical provider may refer the client again as needed.
- If the client misses a scheduled appointment, DSME Program staff will attempt to re-schedule. Staff will notify the referring agency when a client misses two consecutive appointments and request that the medical provider refer again as needed.
- Once the client has completed the DSME Program, staff will fax a follow-up report to the referring medical provider.

If you have questions or concerns regarding this process, please feel free to contact DSME Program staff, 919-245-2381. Thank you once again for your referral.

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919-245-2380



Diabetes Self-Management Education Program REFERRAL FORM

Client's name: _____ **SS#:** _____ **Health Insurance** _____

Address: _____

DOB: _____ **Phone #:** _____ **Today's Date:** _____

Diabetes Diagnosis:

- Type 1, controlled 250.01 Type 1, uncontrolled 250.03 Type 2, controlled 250.00
 Type 2, uncontrolled 250.02 Gestational 648.00 Pre-Existing DM with Pregnancy
 Pre-diabetes 790.29 Other: _____

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 _____

Height: _____

Weight: _____

BMI: _____

Recent Labs:

- FBG: _____ Date: _____
 A1C: _____ Date: _____
 Micro-albumin: _____ Date: _____
 Total Cholesterol: _____ Date: _____
 HDL: _____ Date: _____
 LDL: _____ Date: _____
 BP: _____ Date: _____
 Triglycerides: _____ Date: _____

Education Needed:

- Comprehensive Self Management Skills (group) Basic Nutrition Management
 Comprehensive Self Management Skills (individual sessions) Self blood glucose monitoring
 Insulin Instruction Insulin Pump Instruction
 Medical Nutrition Therapy (MNT) (**Please use OCHD MNT Referral Form**)
 Management of Diabetes during Pregnancy/Gestational Diabetes Education

Indicate any existing barriers requiring customized education:

- Impaired mobility Impaired vision Impaired hearing Impaired dexterity
 Language barrier Impaired mental status/cognition 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)

Provider's Name (Printed): _____ **Practice Name:** _____

Provider's Signature: (Required) _____

Office Address, Phone Number: _____

**Please Fax Referral Form to: 919-644-3312
For Questions, Please Call: 919-245-2381**