

Diabetes Self-Management Program REFERRAL FORM

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

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

Diabetes Diagnosis:

- | | | |
|--|---|---|
| <input type="checkbox"/> Type1, controlled 250.01 | <input type="checkbox"/> Type1, uncontrolled 250.03 | <input type="checkbox"/> Type 2, controlled 250.00 |
| <input type="checkbox"/> Type 2, uncontrolled 250.02 | <input type="checkbox"/> Gestational 648.00 | <input type="checkbox"/> Pre-Existing DM with Pregnancy |
| <input type="checkbox"/> Pre-diabetes 790.29 | <input type="checkbox"/> 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:

- | | |
|---|-------------|
| <input type="checkbox"/> FBG _____ | Date: _____ |
| <input type="checkbox"/> A1C _____ | Date: _____ |
| <input type="checkbox"/> Micro-albumin _____ | Date: _____ |
| <input type="checkbox"/> Total Cholesterol: _____ | Date: _____ |
| <input type="checkbox"/> HDL _____ | Date: _____ |
| <input type="checkbox"/> LDL: _____ | Date: _____ |
| <input type="checkbox"/> Triglycerides: _____ | Date: _____ |

Education Needed:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Comprehensive Self Management Skills (group) | <input type="checkbox"/> Basic Nutrition Management |
| <input type="checkbox"/> Comprehensive Self Management Skills (individual sessions) | <input type="checkbox"/> Self blood glucose monitoring |
| <input type="checkbox"/> Insulin Instruction | <input type="checkbox"/> Insulin Pump Instruction |
| <input type="checkbox"/> Medical Nutrition Therapy (MNT) (**Please use OCHD MNT Referral Form**) | |
| <input type="checkbox"/> 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**