Diabetes Education Referral

Date of Referral_____ **Physician\Phone**_____

Patient Name_____ **DOB**_____

Address_____

Phone_____ **Email**_____

Insurance Co. Name_____ **Policy #**_____

Reason for Referral:
- □ New Onset
- □ Change in treatment
- □ Recurrent elevated glucose levels
- □ Recurrent hypoglycemia
- □ Recent hospitalization for DKA or HHNS
- □ Recurrent utilization of diabetes services via emergency room, hospital, physician's office, or clinic

Diagnosis:
- □ 250.00 Type 2
- □ 250.01 Type 1
- □ 250.02 Type 2, uncontrolled
- □648.8 Gestational
- □ 648.0 Pregnant with diabetes

Last HgbA1c_____**Chol**_____ **HDL**_____ **LDL**_____ **Trig**_____

Height_____ **Weight**_____ **Exercise\Activity Restrictions**_____

Management Plan of Care:
- □ Individual Diabetes Self Management Training (G0108)
- □ Group Diabetes Self Management Training (G0109)
- □ Insulin instruction
- □ Glucometer instruction
- □ Gestational Diabetes Management ($10)
- □ Insulin pump start up (by certified pump trainer)

Diabetes Complications:

□ Retinopathy	□ Nephropathy	□ Hypertension
□ Neuropathy	□ Dermatopathy	□ Gastroparesis
□ Cardiovascular disease	□ Hyperlipidemia	□ Other_____

I certify that Diabetes Self Management Training (DSMT) is needed for this patient.

Physician Signature and Date:_____

Fax to Tracie Vaughan, RN, Diabetes Education Program 276-236-9594