Dartmouth-Hitchcock
MEDICAL CENTER

Phone: (603) 650-8630
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Referral Form
Diabetes Self Management Program

Patient Name: _____ Today's Date: _____

DOB: _____ SSN: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Health Insurance: _____ Policy #: _____

Referring Provider: _____ Office #: _____

Practice Name: _____ Fax #: _____

Diabetes Diagnosis:

- ❑ Type 1, controlled
- ❑ Type 1, uncontrolled
- ❑ Type 2, controlled
- ❑ Type 2, uncontrolled
- ❑ Gestational
- ❑ Pre-diabetes
- ❑ Pre-existing DM with pregnancy

Current Treatment:

- ❑ Diet & exercise
- ❑ Oral agents: _____
- ❑ Insulin: _____

Indicate one or more reasons for referral:

- ❑ Recurrent elevated blood glucose levels
- ❑ Recurrent Hypoglycemia
- ❑ Change in DM treatment regiment
- ❑ High risk due to Diabetes complications/co-morbid conditions (check all that apply):
  - ❑ Retinopathy
  - ❑ Neuropathy
  - ❑ Nephropathy
  - ❑ Cardiovascular Disease
  - ❑ Hypertension
  - ❑ Gastroparesis
  - ❑ Hyperlipidemia
  - ❑ Other: _____

Recent Labs:

- ❑ FBG: _____ Date: _____
- ❑ Micro-albumin: _____ Date: _____
- ❑ Total Cholesterol: _____ Date: _____
- ❑ Triglycerides: _____ Date: _____
- ❑ HgbA1C: _____ Date: _____
- ❑ HDL: _____ Date: _____
- ❑ LDL: _____ Date: _____

Education needed:

- ❑ Comprehensive self management skills (group)
- ❑ Comprehensive self management skills (individual sessions)
- ❑ Medical Nutrition Therapy (MNT)
- ❑ Management of Diabetes during pregnancy/ Gestational Diabetes Education
- ❑ Insulin instruction
- ❑ Insulin pump instruction
- ❑ Basic nutrition management
- ❑ Self blood glucose monitoring

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)

Physician's signature (required): _____