

**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:**

- |   |   |                                       |   |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> Type 1, controlled   | <input type="checkbox"/> Type 2, controlled   | <input type="checkbox"/> Gestational  | <input type="checkbox"/> Pre-existing DM with pregnancy |
| <input type="checkbox"/> Type 1, uncontrolled | <input type="checkbox"/> Type 2, uncontrolled | <input type="checkbox"/> Pre-diabetes |   |

**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 regimen
- High risk due to Diabetes complications/co-morbid conditions (check all that apply):
- |                                       |  |   |   |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Retinopathy  | <input type="checkbox"/> Neuropathy    | <input type="checkbox"/> Nephropathy    | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Gastroparesis | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Other: _____           |

**Recent Labs:**

- |   |  |
|---|--|
| <input type="checkbox"/> FBG: _____ Date: _____               | <input type="checkbox"/> HgbA1C: _____ Date: _____ |
| <input type="checkbox"/> Micro-albumin: _____ Date: _____     | <input type="checkbox"/> HDL: _____ Date: _____    |
| <input type="checkbox"/> Total Cholesterol: _____ Date: _____ | <input type="checkbox"/> LDL: _____ Date: _____    |
| <input type="checkbox"/> Triglycerides: _____ Date: _____     |  |

**Education needed:**

- |   |  |
|---|--|
| <input type="checkbox"/> Comprehensive self management skills (group)                               | <input type="checkbox"/> Insulin instruction           |
| <input type="checkbox"/> Comprehensive self management skills (individual sessions)                 | <input type="checkbox"/> Insulin pump instruction      |
| <input type="checkbox"/> Medical Nutrition Therapy (MNT)  | <input type="checkbox"/> Basic nutrition management    |
| <input type="checkbox"/> Management of Diabetes during pregnancy/<br>Gestational Diabetes Education | <input type="checkbox"/> 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):** \_\_\_\_\_