

Referral for Diabetes Self-Management Training

For diabetes office use only

Name: _____ DOB: _____ Phone - H _____ W _____

Address: _____ City/State _____ Zip _____

Type of Diabetes & Complications	Medical Condition	Self-Management Training Requested																																	
<p>Type of Diabetes</p> <p><input type="checkbox"/> New Onset Date of onset: _____</p> <p><input type="checkbox"/> Type 1 (250.1)</p> <p><input type="checkbox"/> Type 1, uncontrolled (250.3)</p> <p><input type="checkbox"/> Type 2 (250.0)</p> <p><input type="checkbox"/> Type 2, uncontrolled (250.2)</p> <p><input type="checkbox"/> Pre-Diabetes (May not be covered by insurance)</p> <p>Complications of Diabetes (Check all that apply)</p> <p><input type="checkbox"/> Nephropathy (250.4)</p> <p><input type="checkbox"/> Retinopathy (250.5)</p> <p><input type="checkbox"/> Neuropathy (250.6)</p> <p><input type="checkbox"/> Peripheral Vascular Disease (250.7)</p> <p><input type="checkbox"/> Specified Hypoglycemia (250.8)</p> <p><input type="checkbox"/> Pregnancy w/diabetes (648.0)</p> <p><input type="checkbox"/> Other _____</p>	<p>Health Hx:</p> <table border="0"> <tr> <td></td> <td style="text-align: center;"><i>Recent Labs</i></td> <td style="text-align: center;"><i>Date</i></td> </tr> <tr> <td>Blood Glucose</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>HbA1c</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Cholesterol</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Triglycerides</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>HDL</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>LDL</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Microalbuminuria</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Height</td> <td>_____</td> <td></td> </tr> <tr> <td>Weight</td> <td>_____</td> <td></td> </tr> <tr> <td>Blood Pressure</td> <td>_____</td> <td></td> </tr> </table> <p>Check Diabetes Medication Regimen</p> <p><input type="checkbox"/> None <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Pills</p> <p>List dose, route, time: _____ _____ _____</p> <p>• Have patient bring list of other current medications to their first appointment</p>		<i>Recent Labs</i>	<i>Date</i>	Blood Glucose	_____	_____	HbA1c	_____	_____	Cholesterol	_____	_____	Triglycerides	_____	_____	HDL	_____	_____	LDL	_____	_____	Microalbuminuria	_____	_____	Height	_____		Weight	_____		Blood Pressure	_____		<p>Living with Diabetes Series:</p> <p><input type="checkbox"/> The Basics Class:</p> <ul style="list-style-type: none"> • Initial Assessment / Pre-HbA1c • Basic Management & Monitoring • Meal Planning (see * below) • Behavior Change and Coping • Follow-up Visit & Post A1C <p>Individual Consultation: <i>Choose all that apply -</i></p> <p><input type="checkbox"/> Basic Management & Monitoring</p> <p><input type="checkbox"/> Medical Nutrition Therapy(see * below)</p> <p><input type="checkbox"/> Insulin Initiation</p> <p><input type="checkbox"/> Assessment of Management Skills</p> <p><input type="checkbox"/> Pre-Pregnancy Planning (see * below)</p> <p><input type="checkbox"/> Other _____</p> <p>[Gestational - please use Pregnancy Referral]</p> <p>*Medical Nutrition Therapy</p> <p><input type="checkbox"/> RD to determine calorie/ carbohydrate level</p> <p><input type="checkbox"/> Preferred calorie level is _____</p> <p><input type="checkbox"/> Carbohydrate Counting (RD to determine ratio)</p> <p>Additional recommendations: _____</p>
	<i>Recent Labs</i>	<i>Date</i>																																	
Blood Glucose	_____	_____																																	
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Height	_____																																		
Weight	_____																																		
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Referral Clerk

1. Insurance Company: _____
2. Pre-Authorization #: _____
 No pre-authorization required
3. Patient's insurance **Does Does Not** cover Diabetes Education
(Circle one)

- Exercise Activity**
- Unrestricted
- Moderate to light walking
- Contraindicated (not appropriate for this patient)

Physician: Print name / Signature

Date