New Hanover County
Health Department
2029 South 17th Street
Wilmington, NC 28401-4946

Patient's name____________________ **SS#** ____________________ **Health Insurance**_____________

DOB: ___________________ **Phone #** _________________________**Today's Date:** ________________

Race: _________________________

Diabetes Diagnosis:

☐Type I, controlled ☐Type I, uncontrolled ☐Type 2, controlled ☐Type 2, uncontrolled
☐Gestational ☐Pre-Existing DM with Pregnancy

Current Treatment

☐ Diet and 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** ______________ **Blood Pressure** ________________

Recent Labs:

FBG __________________ Date: ___________
Hgb A1C _______________ Date: ___________
Micro-albumin ___________ Date: ___________
Total Cholesterol_________ Date: ___________
HDL ___________________ Date: ___________
LDL ___________________ Date: ___________
Triglycerides: ____________ Date: ___________

Education needed

☒ Comprehensive Self Management Skills (group)
☐Insulin Instruction
☐Medical Nutrition Therapy (MNT) ☐Self blood glucose monitoring
☐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 state/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 Signature: (Required) ____

Provider's Name: (Printed) ____

Referring Facility ________________________**Telephone** ________________________________

Fax Referral Form to: 910-772-7805
Questions: 910-798-6595 or 910-798-6594

DIAB014
01-2013