

**Diabetes Self Management Program
PHYSICIAN REFERRAL FORM**

Patient's name: _____ **Health Insurance** _____

DOB: _____ **Phone #:** _____ **Race:** _____ **Today's Date:** _____

Diabetes Diagnosis:

- Type 1, controlled Type 1, uncontrolled Type 2, controlled Type 2, uncontrolled
 Gestational Pre-Existing DM with Pregnancy Pre-diabetes

Current Treatment:

- Diet & 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** _____

Recent Labs:

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

Education Needed:

- Comprehensive Self Management Skills (group)
 Comprehensive Self Management Skills (individual sessions)
 Insulin Instruction Basic Nutrition Management
 Self blood glucose monitoring
 Management of Diabetes during Pregnancy/Gestational Diabetes Education
 Insulin Pump Instruction

Indicate any existing barriers requiring customized education:

- Impaired mobility Impaired vision Impaired hearing Impaired dexterity
 Language barrier Impaired mental status/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)

Physicians' signature: (Required) _____

Physician's Name (Printed): _____

Telephone _____

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