Diabetes Self Management Program: REFERRAL FORM

Patient's Name: _____ SS#: _____ Health Insurance: _____

DOB: _____ Phone #: _____ 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:

BP:_____ Date:_____

FBG: _____ Date: _____

HgbA1C: _____ Date: _____

Micro-albumin: _____ Date: _____

Total Cholesterol: _____ Date: _____

HDL: _____ Date: _____

LDL: _____ Date: _____

Triglycerides: _____ Date: _____

Education Needed:

☐ Comprehensive Self Management Skills: ☐ Group ☐ Individual

☐ Basic Nutrition Management ☐ Medical Nutrition Therapy (MNT)

☐ Self Blood Glucose Monitoring ☐ Gestational Diabetes Education

Indicate and 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).

Provider's Signature (Required): _____

Provider's Name (Printed): _____ **Phone:** _____

Durham County Department: of Public Health | Nutrition Division

Fax Referral Form to: (919) 560-7786 Questions: (919) 560-7788