Diabetes Self Management Program

REFERRAL FORM

Patient's Name: SS#: DOB:

Phone No.: Health Insurance: Today's Date:

Diabetes Diagnosis:

☐ Type 2, controlled ☐ Type 1, controlled ☐ Pre-diabetes

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

Current Treatment:

☐ Diet & Exercise ☐ Oral Agents:

☐ Insulin:

Indicate one or more reasons for referral:

☐ Newly-diagnosed

☐ Recurrent elevated blood glucose levels

☐ Recurrent Hypoglycemia

☐ Change in DM treatment regimen

☐ High Rrisk due to Diabetes Complications/Co-morbid conditions:

☐ Retinopathy ☐ Neuropathy ☐ Nephropathy ☐ Gastroparesis ☐ Hyperlipidemia

☐ Hypertension ☐ Cardiovascular disease ☐ Other:

Height: _____ Weight: _____ BP: _____

Recent Labs:

Date:_____ HgbA1c:_____ Date:_____ Micro-albumin: _____

Date:_____ Cholesterol:_____ HDL:_____ LDL:_____ Triglycerides: _____

Education Needed:

☒ Comprehensive Self-Management Skills: ☐ Individual OR ☐ Group

☐ Insulin Instruction ☐ Self blood glucose monitoring ☐ Medical Nutrition Therapy (MNT)

☐ 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

☐ Eating disorder ☐ Impaired mental status/cognition

☐ 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):_____



Albemarle Regional Diabetes Care Program
711 Roanoke Avenue
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**FAX Referral Form to: 252-337-7911**
**QUESTIONS: Waynette Speight, RN,BSN,CDE: 252-338-4370**