



Diabetes Self Management Program
REFERRAL FORM

Patient's name: Payor Source

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 Blood Pressure:

Recent Labs:

- FBG Date:
HgbA1C Date:
Micro-albumin Date:
Total Cholesterol: Date:
HDL Date:
LDL: Date:
Triglycerides: Date:

Education Needed:

- Comprehensive Self-Management skills
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 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):

Telephone

Harnett County Health Department
Fax Referral Form to: 910-814-4060
Questions:910-814-6240