Use Ball Point Pen Only

DIABETES SELF-MANAGEMENT PROGRAM REFERRAL FORM

Randolph Health Diabetes & Nutrition Center FAX TO (336) 625-9500

PLEASE ATTACH COPY OF THE FRONT/BACK OF **INSURANCE CARD**, RELEVANT **OFFICE NOTE** & MOST RECENT **LAB REPORTS** **If you have questions, please contact us at (336) 625-9400**

Patient Information

Name: _____ DOB: __/___/____ Phone: _____

Address:_____

Insurance: _____ Ht: _____ Wt: _____

Diagnosis ICD-10 Codes

☐ _____**Dietary Counseling/Surveillance**

☐ _____DM Type 1 without complication

☐ _____DM Type 2 without complication

☐ _____Other ICD-10 code

Educational Needs

☐ Newly diagnosed
☐ Needs updated education
☐ No prior education
☐ Needs improved DM control

Barriers

Does patient require individual sessions?
☐ Yes ☐ No
If yes, please specify below:
☐ Language
☐ Hearing Impairment
☐ Visual Impairment
☐ Cognitive Deficit
☐ Physical of emotional limitations
☐ Other: _____

Date:	***Lab Result***
HbA1C	
T. Chol	
HDL	
LDL	
Trig	

Diabetes Self-Management Training

Check desired plan for patient education:

☐ **Initial Plan of Care (9 hrs total, in small groups)**

- Assessment (3 hrs)
  Assessment of education needs, diabetes disease process, intro to carbohydrates
- Core Education Class (3 hrs)
  Psychosocial issues, medications, monitoring blood glucose, complications, behavior change
- Meal Planning (3 hrs)
  Physical activity & nutrition -RD will choose meal plan unless MD specifies.
  Calories/day _____

☐ **Follow-up Diabetes Training (2 hr)**

- Available yearly to Medicare recipients one year after initial training.

☐ **Glucometer Instruction (1/2 - 1 hr session)**

- Time of day preference? _____
- Frequency of monitoring? _____ times/day

☐ **Insulin Instruction (1-2 hr sesson)**

- Insulin type _____
- Dosage _____ Time_____
  ☐ Pen ☐ Syringe

☐ **Meal Planning Group Class (3hr, see above)**

☐ **Carbohydrate Counting**

- To assist patient with assessment of carb intake for anticipated insulin pump use

Provider Information

Referring Provider Printed Name:

_____

Signature: _____

Date: _____Time:_____

Phone: _____

Fax: _____

Randolph Health