MidMichigan Medical Center Clare

Diabetes Education

Physician Referral

(Valid for the following year)

Please call Central Scheduling at (989) 802-8805 to schedule appointment
Fax required referral form to (989) 802-8838

Patient Information:

Date of referral: _____
Name _____Date of Birth _____
Phone (Home) _____(Work) _____
Health Insurance _____

Diagnosis (check all appropriate boxes)

☐ **Type 2 controlled**	**250.00**	☐ **Type 1 controlled**	**250.01**	☐ **Long term insulin use**	**V58.67**
☐ **Type 2 uncontrolled**	**250.02**	☐ **Type 1 uncontrolled**	**250.03**	☐ **Gestational DM**	**648.8x**
Co morbidities:					
☐ Hypertension	401.9	☐ DM Peripheral Neuropathy	250.6	☐ Diabetic Nephropathy	250.4
☐ Diabetic retinopathy	250.5	☐ Dyslipidemia	272.4	☐ ESRD	585.6

Reason for Training:

☐ New Onset of Diabetes
☐ Inadequate Glycemic Control
☐ Severe hypoglycemia or hyperglycemia
☐ Change in Treatment regimen:
  ☐ from no DM meds to any DM meds *OR*
  ☐ from orals to insulin (please outline Insulin Start below)
☐ Complications (Please Detail):_____
_____
☐ Diabetes Update

Training Ordered: Must choose at least one of the following

☐ **Diabetes Class : DSMT Comprehensive Training** (*Group Education required by Medicare unless special needs indicated.)*
SPECIAL NEEDS: ☐ Language barrier ☐ Impaired vision/hearing ☐ Other (specify) _____
☐ **Follow up Training** *(DSMT. Medicare allows 2 hours yearly)*
☐ **Individual Dietitian Consultation** (*Medical Nutrition Therapy. Medicare allows 3 hours first year,2 hours yearly thereafter.*)
☐ **Individual Nursing Consultation** *(Individual assessment and education with RN)*
  ☐ **Self Blood Glucose Monitor Training** *(Please provide script for meter supplies)*
  ☐ **Insulin/Injectables Start** (check one of following)
    ☐ Patient to contact provider for all adjustments. Starting Dose: _____
    ☐ Instruction for orals when insulin is begun:_____

Other Orders:

☐

Current Diabetes Medications (please specify name, dose, timing)

Insulin Regimen	Oral Agents	Other

**Please fax recent relevant labs, including A1c, microalbumin, lipid profile. **

I certify that I am managing this patient's condition and the education described in the Plan of Care is needed to provide this patient with the skills and knowledge to help manage his/her condition.

Physician Signature _____Date: _____

Physician Name (printed) _____