# *Diabetes Referral*

***MidMichigan Medical Center Gladwin Diabetes Center***
**Phone (989) 246-6292 Fax (989) 246-6400**

## *Patient Information*

Patient Name _____ Date of Birth _____
Patient Address _____ City/Zip Code _____
Phone Home _____ Work _____
Health Insurance _____ Appointment Date and Time_____

## *Reason for Training*

☐ New Diagnosis of Diabetes
☐ HbA1c above goal (7.0% for most patients) Result:_____ Date:_____
☐ Severe hypoglycemia or hyperglycemia
☐ Change in Treatment regimen from no DM meds to any DM meds OR from orals to insulin
☐ Start insulin, Dose: _____
☐ Diabetes Annual Follow-Up
☐ Other:_____

## *Education Ordered* *Note: All patients will be instructed on SMBG unless ordered to omit.*

☐ Medical Nutrition Therapy (Dietitian training for diabetes, Medicare allows 3 hours first year, 2 hours yearly thereafter)
☐ Comprehensive Group Training ***Group Education is required by Medicare unless special needs are indicated*.***
☐ Annual Follow up Training (2 hours per year allowed by Medicare)
☐ Individual Nursing & Nutrition Consultation
☐ Insulin Initiation (check one of following)
- ☐ Patient to contact physician for all adjustments. Starting Dose of _____
- ☐ Use Staged Diabetes Management protocols for doses and insulin adjustment
- ☐ Instruction for Oral Meds when insulin begins:_____

***Special Needs:** ☐ ***Language barrier** ☐ ***Impaired vision/hearing** ☐ ***Other**_____

## *Diagnosis and Treatment*

☐ Type 2 ☐ Type 2, uncontrolled (please refer Type 1 Diabetes to Midland Diabetes Center)

**Comorbidities:**
☐ Hypertension ☐ Peripheral vascular disease
☐ Neuropathy ☐ Visual Impairment
☐ Dyslipidemia ☐ ESRD
☐ Other _____

**Laboratory Results: Date_____**
FBS _____ A1C_____ Micro Albumin_____
Chol_____ Trig_____ LDL_____ HDL_____
AST_____ ALT_____ TSH_____ Cr_____
Height_____ Weight_____ BP_____

I certify that I am the health care provider treating this patient's condition and that training is needed to provide this patient with the skills and knowledge to help manage his/her condition.

**Provider Signature _____Date: _____**
Provider Name (printed) _____

**White Copy – Diabetes Center**
**Yellow Copy – Provider**

**Diabetes Center Use----------**
Referral rec'd. _____ Ph Attempt #1_____ #2_____ #3_____ Offered Care_____ Appt. Date_____
New onset diabetes 6 working days · Insulin routine 6 working days · Insulin urgent 3 working days · Diabetes annual f/up 14 working days
Diabetes forms : dsmt referral Sept. 2005