SWEDISH

DIABETES EDUCATION CENTER

PHYSICIAN REFERRAL FORM FOR DIABETES EDUCATION

Patient Demographics

Patient name _____

Patient address _____

_____

Patient phone _____

Patient DOB _____

Patient SSN _____

Patient Health Plan _____

Interpreter needed: ☐ Yes ☐ No

Languages spoken _____

Special Needs: (hearing, vision, emotional, physical, etc.)

_____

Diabetes Medications and doses:

_____

_____

Number of authorized visits approved: _____

Referring Physician Information

Physician name _____

Physician phone _____

Patient Diagnosis Code (Circle)

Diabetes, type 1, controlled	250.01
Diabetes type 1, uncontrolled	250.03
Diabetes, type 2, controlled	250.00
Diabetes, type 2, uncontrolled	250.02
Diabetes with renal manifestations	250.4_____
Pre Diabetes (BG abnormal, high)	790.29
Impaired glucose tolerance test (oral)	790.22
Hypoglycemia	251.2
Abnormal GTT (Gestational Diabetes)	648.83
Other:_____	_____

Most Recent Laboratory Values (please date)

Fasting blood glucose _____

Random blood glucose _____

Glycohemoglobin _____

Blood Pressure _____

Cholesterol _____

LDL _____

HDL _____

Triglycerides _____

OGTT date _____: Fasting = _____ 1 hour = _____ 2 hour = _____ 3 hour = _____

Diabetes Education Programs Available (please select with a check mark)

GROUP EDUCATION CLASSES

☐ Gestational Diabetes Program: Nutrition Therapy and Blood Glucose Monitoring (2 hours), Follow-up class (1 hour)

☐ Pre-Diabetes Class (1 ½ hours)

☐ Diabetes Education/Comprehensive Self-Management Program (total 10.5 hours) (Rec. for Medicare patients unless there are learning barriers).
*First Steps: Monitoring and Introduction to Meal Planning (3 ½ hours)
*Second Steps: Continuation of Self-Management Topics (3 ½ hours)
*Third Steps: Discussion of complications (3 ½ hours)

INDIVIDUAL INSTRUCTION

☐ Comprehensive self-management principles (RN and RD) (Recommended for patients with learning barriers, patients with diabetes out of control or patients requiring 1:1 attention for education)

NUTRITION

☐ Instruct regarding carbohydrate counting. Other special diet needs: _____

INSULIN ADMINISTRATION

☐ Instruct regarding insulin administration; Starting Dose:_____

☐ Diabetes Education Center staff to recommend dose and confirm with referring physician

☐ Follow-up with Diabetes Education Center staff to adjust insulin for 2 weeks per Diabetes Education Center protocol and refer back to prescribing physician

☐ Patient to contact prescribing physician for insulin dose adjustment after instruction

☐ Evaluate present insulin regimen

☐ Begin basal insulin and mealtime rapid action insulin boluses; starting Dose:_____ or

☐ Diabetes Education Center staff to recommend dose and confirm with referring physician

☐ Determine carbohydrate to insulin ratio and instruct patient in its use

☐ Determine correction factor and instruct patient in its use

INSULIN PUMP THERAPY

☐ Initial patient assessment for pump therapy (RN & RD) _____Initial patient assessment for sensor prescription

☐ Assessment for pump upgrade

☐ Evaluation of current pump management and recommendation for basal and/or bolus change

BYETTA/SYMLIN THERAPY

☐ Instruct regarding _____ Byetta _____ Symlin administration; starting dose:_____

☐ Follow-up with Diabetes Education Center staff to adjust_____ refer back to physician for adjustment

OTHER

☐ Patient is medically cleared for exercise

☐ Diabetes Education Center may order appropriate diabetes supplies (i.e.: strips, lancets and ketostix)

Physician Signature _____ **Date** _____

PLEASE FAX TO THE SWEDISH DIABETES EDUCATION CENTER AT (206) 215-2457 Phone: 206-215-2440