JOHNSTON
UNC HEALTH CARE

Diabetes Outpatient Referral Form

Please call and fax this sheet to schedule appointments.

Community Wide Scheduling
509 N. Bright Leaf Blvd., Smithfield, NC 27577
Phone: 919-938-7749 Fax: 919-989-6584

I am referring _____ for medically necessary outpatient self-management education.
Date of Birth:_____ Physician:_____
Daytime Phone:_____ Evening Phone:_____
Address:_____ Language:_____
Special Needs: ____Vision ____Hearing ____Language ____Eating disorder ____Dexterity ____Mental
Exercise Activity: ____Unrestricted ____Moderate to Light ____Not appropriate for this patient

Note to Physician: Each patient referred for outpatient diabetes education classes receives an initial assessment which includes blood sugar checks, patient goals, and/or discussions of topics the patient does not want to share in a group class. This takes approx. one hour and 30 minutes. If appropriate, these patients will be scheduled for the group class lasting approx. 7 hours where 2 of those hours are with a dietician. Lastly, we do a 3 month follow-up to see how well your patient is doing with their goals and any additional help the patient may need.

Insurance Information	**Authorization #**	**Diagnosis ICD- 9/10 codes: _____**	**Medical Conditions:**
Healthsource	_____	_____ ***Type 1, Controlled***	_____ Newly Diagnosed
Doctor's Health Plan	_____	_____ **Type 1, Uncontrolled**	_____ New to Insulin
BCBS	_____	_____ **Type 2, Controlled**	_____ New to Orals
Healthsource	_____	_____ **Type 2, Uncontrolled**	_____ Gestational
Prudential	_____	_____ **Pre-Existing DM with Pregnancy**	_____ Severe hyperglycemia
Medicare	_____	_____ **Gestational**	_____ Severe hypoglycemia
Medicaid	_____	_____ **Pre-diabetes**	_____ Change in DM treatment
		_____ **Other**	_____ Other

Complications: _____ Vascular _____ Neuropathy _____Retinopathy Other: _____

Recent Lab Results: *HbA1c*_____ (date) Prior to class

BP_____ Triglycerides_____ Cholesterol_____ LDL_____
HDL_____ Mircro-albumin_____ Fasting Blood Sugar_____

Nutritional Counseling Only
Obese _____
Weight Gain _____
Other _____

Plan of Care: Weight Management _____ Weight Now _____
Weight Goal _____ Carbohydrate Counting _____

Gestational Diabetes or Patient Pregnant with Diabetes
Desired blood sugar range: Fasting _____ 1 hr. pp _____
2 hr. pp _____ Pre-pregnancy Weight _____
Follow-up Monthly _____
Insulin _____ mixing _____ NPH _____
Regular_____ Other _____

Oral Agents: _____ Patient to discontinue oral agents

No _____ Yes _____ Insulin _____ Dosage _____

Physician- please check all three for class.*
1._____ **Diabetes Assessment**
2._____ ***Diabetes Group Class***
3._____ ***Diabetes Follow-up***

_____Individual one-on-one only
_____Diabetes Special Needs
_____SubQ Injections _____Pump Training
_____Sensor _____Gestational
_____Pregnant with diabetes

**Note: The American Diabetes Association suggests you're your patients attend all 3 classes: Assessment, Group and Follow-up to meet ADA guidelines to complete the Diabetes Self-management Program.*

Physician Signature _____ **Date** _____

Special Patient instructions: _____