UNC HEALTH Johnston

Diabetes Education Center

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:

ADA program consists of three parts. An hour-long assessment, 6-hour class and two-hour 3 month follow up. Each patient will receive education following the ADA guidelines. The ADA encourages participating in all three parts to achieve the best long-term outcomes, however, it is not required. Thank You! Antoinette Nelson RN, CDCES and Kelli Wallace RD, CDCES.

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_____

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
_____ Gestational
_____ Pregnant with diabetes

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

Physician Signature _____ **Date** _____

Special Patient instructions: _____