Referral Form for Diabetes Self-Management Education

Diabetes Self-Management Program
Brunswick County Health Services
25 Courthouse Drive
Bolivia, NC 28422
910-253-2250 Fax: 910-253-2370

Date of Referral: _____

Please Fax completed order to:
910-253-2370

Patient Data:
Name: _____
DOB: _____
Phone #: _____

Required: Please attach the following

**Demographic, labs, problem, & medication lists

Diabetes Diagnosis:
☐ Type 1 (ICD-10: E10)
☐ Type 2 (ICD-10: E11)
☐ Other Specified DM (ICD-10: E13)
☐ Gestational (ICD-10: 024.41)
☐ Pre-Existing DM, T1 with Pregnancy (ICD-10: 024.01)
☐ Pre-Existing DM, T2 with Pregnancy (ICD-10: 024.11)
☐ Pre-diabetes (ICD-R73.09)
☐ Other _____

Height: _____ Date: _____
Weight: _____ Date: _____
Blood Pressure: _____ Date: _____

Recent Hgb A1C Lab: (required)
HgbA1C: _____ Date: _____

Complications/Co-morbid conditions:
☐ Retinopathy
☐ Neuropathy
☐ Nephropathy
☐ Gastroparesis
☐ Hyperlipidemia
☐ Hypertension
☐ Cardiovascular disease
☐ Other _____

Indicate one or more reasons for referral:
☐ Newly diagnosed
☐ Recurrent elevated blood glucose levels
☐ Recurrent Hypoglycemia
☐ Change in DM treatment regimen
☐ High risk due to Diabetes Complications

Education Needed:
☐ Comprehensive Self-Management skills (group)
☐ Comprehensive Self-Management skills (individual)

Indicate any existing barriers requiring individual education (required for Medicare):
☐ Impaired mobility
☐ Impaired vision
☐ Impaired hearing
☐ Impaired dexterity
☐ Language barrier
☐ Impaired mental status/cognition
☐ Eating disorder
☐ Learning disability (please specify): _____
☐ Other (please specify): _____
☐ Insulin Instruction
☐ Medical Nutrition Therapy (MNT),
physician signature required for Medicare patients
☐ Self-blood glucose monitoring
☐ Management of Diabetes during Pregnancy/ Gestational Diabetes Education

This patient has clearance to exercise: ☐ Yes ☐ No

I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management.

Provider Signature (Required): _____ Date: _____
Provider's Name (Printed): _____
NPI: _____
Telephone: _____

For Office Use Only:
☐ Patient did not keep appointment
☐ Patient could not be reached to schedule apt.
☐ Patient declined to schedule appointment
☐ Left messages on the following dates to schedule:
_____