ISLAND HEALTH

Scheduling: 360-299-4906
Fax: 360-299-4238

DIABETES EDUCATION PROGRAM REFERRAL FORM

A Program Accredited by the American Association of Diabetes Educators

Patient Information:

Patient's Last Name	First Name	Middle Initial	Date of Birth	Gender
Address (including City, State, Zip Code)			Preferred Patient Phone Number	
Insurance Information				

DIABETES SELF-MANAGEMENT EDUCATION (DSME): *Education will be provided utilizing individual and group sessions as indicated. This referral is for Diabetes Education and Medical Nutrition Therapy (MNT) to manage diabetes care.*

Education provided will be based on needs identified during the patient assessment. The following content areas will be addressed as identified (*the AADE 7 self-care behaviors and diabetes in pregnancy*):

1. Healthy Eating
2. Being Active
3. Monitoring
4. Taking Medication
5. Problem Solving
6. Healthy Coping
7. Reducing Risks
8. Diabetes Management during Pregnancy (if applicable)

Please fax most recent: Lab results, chart note and med list.

Labs: **A1c:** _____ **FBG:** _____ **Total Cholesterol:** _____ **LDL:** _____ **HDL:** _____ **TG:** _____ **eGFR:** _____**Cr:** _____

Physician Sections Below

Diabetes w/o complications __ Type 1(E10.9) __ Type 2(E11.9) **Diabetes w/ complications** __ Type 1(specify code)

_____ Type 2(specify code) _____Gestational Diabetes(024.419) ___ Other _____

Complications/Co-Morbidities: *Check all that apply:* ☐ Hypertension ☐ Neuropathy ☐ Renal disease ☐ Non-healing wound ☐ Mental/affective disorder ☐ Dyslipidemia ☐ Retinopathy ☐ Stroke ☐ PVD ☐ Heart Disease ☐ Obesity

Special Considerations: *Check all that apply:*

☐ Insulin Education/Adjustment

☐ Continuous Glucose Monitor Evaluation

☐ Personal CGM Placement

PCP Signature _____ Date _____

PCP statement: I certify that I am managing this patient's diabetes care and that the training specified above is needed to ensure therapy compliance or to provide the patient with skills and knowledge to help manage the patient's diabetes.