FORT MADISON COMMUNITY HOSPITAL

DIABETES SELF MANAGEMENT PROGRAM EDUCATION REFERRAL FORM

I. Patient Information

Name:_____

Home Phone: _____ Work Phone: _____

Primary Ins: _____ Secondary Ins: _____

II. Diagnosis

□ Type 1 □ Type 2 □ Gestational (#wks. Gestation) _____ □ Impaired Glucose Tolerance

III. Medications (Please list or attach the medication flow sheet.)

1._____ **2.**_____

3._____ **4.**_____

IV. Reason for Referral

□ New Onset DM □ Inadequate Control

V. Specific Educational Needs (check all that apply)

□ Nutrition

- Dietitian to calculate calorie needs: Yes _____ No _____
- Special diet prescription or instructions: _____

_____

□ New Oral Prescription: _____

□ New Insulin Prescription: _____

□ Instruct Glucose Monitoring (Please provide patient with a prescription for a monitor if needed)

□ Instruct on Glucagon Administration (Please provide patient with a prescription)

□ Special needs for 1:1 sessions due to impairment of ***(circle one)*** Visual Hearing Other

VI. Lab Work

Required:
Hgb A1C
Lipid Profile
* Two fasting blood sugars equal or over 126 mg/dl

Recommended:
Urine Microalbumin

This referral includes an individual consult with the dietitian and possibly a nurse educator, an eight hour educational program, and a post-program follow up visit.

Medicare Standards: A fasting blood sugar greater than or equal to 126 mg/dl on two different occasions **or a 2 hour post glucose challenge greater than or equal to 200 mg/dl on two different occasions **or** a random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes.*

Physician Signature: _____Date & Time: _____

Please fax form back to Cathy Mehmert, RD at (319) 376-2065 or place referral form in the Education or Dietary Mailbox. Referral forms can be mailed to 5445 Avenue O P.O. Box 174 Fort Madison, Iowa 52627-0174.