FAX

TO: Department of Health & Human Services Diabetes Team	FROM:
PAGES:	PHONE:
FAX: 252.473.1141	FAX:
SUBJECT: Completed Diabetes Program Referral	DATE:

IMPORTANT
Referral Instructions for Diabetes Programs

1. Please complete this cover sheet & referral form.

2. Attach the following to the completed referral form:

   For patients to qualify for **Diabetes Prevention Program**, they must be 18 years of age; and have a BMI ≥ 25 or ≥ 23 if of Asian descent and, A1C must be between 5.7% - 6.4%. *New classes begin quarterly*

   For patients being referred to the **Diabetes Education Program**, please attach: patient Lab Results (MUST include A1C and date taken) and Patient Medications List. *New classes begin continuously*

   We appreciate additional medical notes so we can better serve your patient. These may also decrease the amount of writing required on the referral form.

3. Fax completed form to 252.473.1141.

In order to comply with HIPAA regulations regarding the transmittal of protected health information, DO NOT PUT PATIENT NAME OR ANY OTHER IDENTIFIERS ON THIS COVER SHEET.

Our Diabetes Team

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County of Dare
Department of Health & Human Services
P.O. Box 669 | Manteo, NC 27954
Health 252.475.5003 | Social Services 252.475.5500 | Veterans Services 252.475.5604 | darenc.com/hhs

Diabetes Programs: Referral Form

Patient Name: _____
Address: _____
_____
DOB: _____ **Race/Sex:** _____
Phone: _____ **Type:** ☐ Cell ☐ Home ☐ Work
Health Insurance/Medicare/Medicaid: _____
Community Care Clinic of Dare to cover cost: ☐ Yes ☐ No
Authorized by: _____
Exercise Restrictions: _____

Weight: _____ **Date:** _____
Height: _____ **Date:** _____
Blood Pressure: _____ **Date:** _____
Frequency of Testing: _____ times per _____

Diabetes Diagnosis:
☐ Prediabetes (A1C of 5.7% - 6.4%)
If selected, STOP after completing shaded box & sign
☐ Type 1, Uncontrolled ☐ Type 1, Controlled
☐ Type 2, Uncontrolled ☐ Type 2, Controlled
☐ Type 2, With Pregnancy ☐ Gestational, Undelivered
☐ Other:_____

Diabetes ICD 10 Code: _____

Diabetes Treated By: ☐ Insulin:_____ ☐ Diet & Exercise:_____
☐ Oral Agent:_____

Existing barriers that impede patient's ability to obtain diabetes self-management skills through group instructions:

☐ Visual/hearing impairment
☐ Impaired mental status/cognition
☐ Eating disorder
☐ Impaired psychosocial status
☐ Impaired mobility
☐ Impaired dexterity
☐ Learning disability:
☐ Language barrier:
☐ Other:

_____ _____ _____

Need for Diabetes Education:

☐ Group Comprehensive Self-Management Skills (includes individual assessment then group education on disease process, nutritional management, physical activity, medications, monitoring, acute complications, chronic complications, psychosocial adjustment, and health promotion/ behavior change)

☐ Individual Comprehensive Self-Management Skills (need barrier to group)

☐ Established Patient Follow-up Education (2 hours per year)

☐ Management of Diabetes during Pregnancy/Gestational Diabetes Education

☐ Self-Blood Glucose Monitoring

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/co-morbid conditions:

☐ Retinopathy, ☐ Neuropathy, ☐ Nephropathy,
☐ Gastroparesis, ☐ Hyperlipidemia, ☐ Hypertension,
☐ Cardiovascular disease

☐ Other:_____

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

Provider's Printed Name: _____ **UPIN/NPI Number:** _____
Provider's Signature: _____ **Date:** _____
Practice Name/Address/Phone: _____

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