Referral Form: Diabetes Self-Management Education & Support Program (DSMES)

Patient Data:

Name:_____

Phone: (_____) _____-_____

Address:_____

_____

D.O.B.:_____/_____/_____
                MM /   DD / YYYY

Insurance type:_____

Policy # :_____

☐ Uninsured

Patient has clearance to exercise?   Yes   No

Education Needed:

☑ Comprehensive Self-Management Skills

Indicate any barriers requiring customized education:

☐ Impaired Mobility
☐ Impaired Vision
☐ Impaired Hearing
☐ Impaired Dexterity
☐ Impaired Mental Status/Cognition
☐ Eating Disorder
☐ Learning Disability
  (Specify)_____
☐ Language Barrier
☐ Interpreter needed
  (Specify)_____

Diabetes Diagnosis:
☐ Type 1, controlled
☐ Type 1, uncontrolled
☐ Type 2, controlled
☐ Type 2, uncontrolled

➢ **ICD Code:**_____

Indicate Reason for Referral:
☐ Newly Diagnosed
☐ Recurrent Hyperglycemia
☐ Recurrent Hypoglycemia
☐ Change in DM Treatment Regimen
☐ High Risk/DM
☐ Complications/Comorbidities

➢ **Hgb A1c_____%**

Provider Data:

Name:_____

Practice:_____

Phone: (_____) _____-_____

Fax : (_____) _____-_____

NPI: _____

Signature:_____

Date:_____/_____/_____
        MM /   DD / YYYY