



Patient Name: _____

Patient MRN: _____

Preferred Class Time: 8:30AM / 1:00PM / 5:30PM
(Circle One)

Endocrinology Diabetes Education Referral Form

Fax this form to 254-215-0325 or send original to Diabetes Education, Endocrinology Dept, Desk M1

Referral Information (to be entered by referring physician)

Requesting Provider & Doctor Number: _____ Date of Request: _____

Reason for Referral:

New onset diabetes Uncontrolled diabetes Impaired fasting glucose/impaired GTT Frequent or severe hypoglycemia

Other (please specify) : _____

Patient's Diabetes Diagnosis:

Type 1 uncontrolled Type 1 controlled Type 2 uncontrolled Type 2 controlled

Other (please specify) : _____

Barriers requiring individual rather than group diabetes instruction:

None Vision Hearing Language limitations Cognitive Physical challenge

Other (please specify) : _____

Patient Information for Class (to be entered by diabetes educator or referring physician)

Current Diabetic Medications: _____ HgbA1C & Date: _____

None Oral (type & dose) _____ Insulin (type & dose) _____

Current Complications or Comorbidities:

None HTN Dyslipidemia Neuropathy Stroke Nephropathy
 Non-healing wound Obesity Retinopathy PVD CHD Affective disorder

Other (please specify) : _____

I certify that I am managing this patient's condition and the education described in the Plan of Care. The Plan of Care is needed to provide this patient with the skills and knowledge to help manage their diabetes.

Provider Signature: _____ Date: _____