SCOTT & WHITE

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:** ____________________________

MR Form D3220-100 1/08