Charleston Area
Medical Center
Charleston, West Virginia

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OUTPATIENT DIABETES EDUCATION PROGRAM REFERRAL FORM

PLACE
PATIENT IDENTIFICATION LABEL
HERE

Patient's name: _____ DOB:_____ Gender: ❒ M ❒ F

Address:_____

Phone Numbers: _____

Diabetes Diagnosis:

❒ Impaired Fasting Glucose 790.21 ❒ Impaired Glucose Tolerance (oral) 790.22 ❒ Gestational 648.83
❒ Type 1 _____ ❒ Type 2 _____ ❒ Diabetes with Pregnancy

Patient is to attend the following:

❒ Comprehensive Diabetes Self Management Training
❒ Diabetes and Pregnancy Training
❒ Nutrition Management (1:1)
❒ Self Blood Glucose Monitoring (1:1)
❒ Insulin Instruction (1:1)
❒ Other _____

Lab Results (please attach a copy of the most recent labs)
Medications (please attach a copy of the most current medication)

Patient has special need(s). Check all that apply.

❒ Vision ❒ Hearing ❒ Physical disability ❒ Cognitive Impairment ❒ Language barrier ❒ Illiteracy
❒ Other_____

Provider issues/concerns_____
_____
_____
_____

As a health care provider treating this person's condition, I certify that diabetes self-management training/medical nutrition therapy is needed under a comprehensive plan of care to ensure therapy compliance and/or to provide the necessary knowledge/skills the patient needs to manage his/her condition.

Print Provider Name: _____ UPIN Number: _____

Phone Number: _____Fax Number: _____

Note: Health plans may not cover this service. The patient should contact their health plan to determine if service is covered or if pre-authorization is necessary. Please fax completed form, lab results, medication list, and copy of patient's insurance information to the program coordinator at **388-5560**.

DATE:	**TIME:**	**SIGNATURE:**
Required	***Required)***	***Required***