

## Referral for Diabetes Self-Management Training and Education *ediba* Diabetes Center of Excellence

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Preferred phone (h/w) \_\_\_\_\_

Address \_\_\_\_\_ City / State \_\_\_\_\_ ZIP \_\_\_\_\_

Soc Sec # \_\_\_\_\_ Gender: M / F Race: AF AS Cau Hisp Nat Amer Other \_\_\_\_\_ INS. CO. \_\_\_\_\_

Marital Status : M S W D Sep. Partner Ht \_\_\_\_\_ Wt \_\_\_\_\_ (for GDM: Pre-Preg. WT \_\_\_\_\_ Religious Pref. \_\_\_\_\_

Date/results from your reords: B/P \_\_\_\_\_ Microalbumin \_\_\_\_\_ Blood Glucose \_\_\_\_\_ A1C \_\_\_\_\_ Cholesterol: Total \_\_\_\_\_ HDL \_\_\_\_\_ LDL \_\_\_\_\_ Triglycerides \_\_\_\_\_

Diagnosis codes:	Type of diabetes	4 <sup>th</sup> digit-	Complications of diabetes
(circle) 250.__0	type 2, not stated as uncontrolled	.0__	Diab w/o complication
		.1__	Ketoacidosis w/o coma
250.__1	type 1, not stated as uncontrolled	.2__	Hyperosmolarity (HHNS)
		.3__	Other coma (keto/hypo)
250.__2	type 2, uncontrolled		.6__ Neuroopathy
250.__3	type 1, uncontrolled		.7__ PVD
648.8__	Gestational diabetes		.8__ Specified hypoglycemia
648.0__	Pregnancy w/ diabetes		.9__ Unspecified Complication
			227.7 Metabolic Syndrome
			790.6 Hyperglycemia
			__ . __ Other _____

**Medical necessity due to Diabetes Mellitus** (please check)

- Type 1
- Type 2
- Gestational Diabetes
- Pregnancy w/ preexisting diabetes

**NOTES:**

**Patient information**

- Newly Diagnosed
- Ineffective coping
- Existing barriers to learning
  - \_\_ Learning disability
  - \_\_ Impaired dexterity
  - \_\_ Eating disorders
  - \_\_ Other \_\_\_\_\_
- Recurrent hypoglycemia or hypoglycemia unawareness
- Recent / frequent hospitalization for DKA or HHNS
- Chronic complications
  - \_\_ Retinopathy
  - \_\_ Cardiovascular disease
  - \_\_ Peripheral vascular disease
  - \_\_ Cerebrovascular disease
  - \_\_ Other \_\_\_\_\_
  - \_\_ Nephropathy
  - \_\_ Hypertension
  - \_\_ Dyslipidemia
  - \_\_ Gastroparesis
  - \_\_ Dermopathy
  - \_\_ Neuropathy

**Recommended Management Plan / Special Instructions**

Current meds:

**Education requested**

- \_\_ Type 2
- \_\_ Type 1
- \_\_ Insulin Pump Therapy (Prepump and Pump training)
- \_\_ Advanced Insulin Management
- \_\_ Gestational program
- \_\_ Other: \_\_\_\_\_

I am referring this patient to the ediba Diabetes Center of Excellence for diabetes self-management training which is medically necessary and integral to care and in accordance with the National Standards of Medical Care for People with Diabetes (ADA).

Physician's Signature: (required) \_\_\_\_\_ Printed name: \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ City / State / Zip \_\_\_\_\_ Fax \_\_\_\_\_

**Please fax completed referral to:**

**Ediba Diabetes Center at INTEGRIS Baptist Medical Center**

**3433 NW 56 Blg. B -suite C-70 OKC, OK 73112**

**(405) 949-6000 fax (405) 949-6093**

