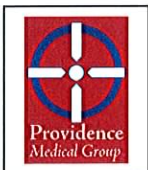

Providence Diabetes Center Referral Form

Please fax this referral with current labs and copy of insurance card to: (937) 298-9673

Patient Name:	Date of Birth:
MR#:	Daytime Phone:

Diagnosis Code:
- ❑ Type 1 controlled (250.01)
- ❑ Type 1 uncontrolled (250.03)
- ❑ Type 2 controlled (250.00)
- ❑ Type 2 uncontrolled (250.02)
- ❑ Gestational (648.83)
- ❑ Prediabetes (790.29)

Current diabetes treatment:
- ❑ Meal planning and exercise
- ❑ Oral medication: ______________________
- ❑ Insulin: ______________________________
- ❑ Other: _______________________________

Reason for Training:
- ❑ New onset diabetes (within last 12 months)
- ❑ Inadequate glycemic control
- ❑ Change in condition or treatment regimen

Comorbidities:
- ❑ Hypertension
- ❑ Cardiovascular disease
- ❑ Hyperlipidemia
- ❑ Peripheral vascular disease
- ❑ Retinopathy
- ❑ Neuropathy
- ❑ Nephropathy
- ❑ Other: ______________

Type of training being ordered:

❑ **GROUP: Comprehensive Diabetes Self-Management Education Class**
(9 hours in 3 visits with nurse and dietitian)

❑ **INDIVIDUAL: Comprehensive Diabetes Self-Management Education**
(1 hour with nurse and 1 hour with dietitian, additional follow-up appointments as needed)
This patient cannot effectively participate in group instruction due to the following reason:
- ❑ Visual/Hearing impairment
- ❑ Language barrier
- ❑ Impaired mental status
- ❑ Impaired mobility
- ❑ Impaired psychosocial status
- ❑ Learning disability
- ❑ Other: __________________________

❑ **GROUP: Diabetes Refresher Class for patients with previous comprehensive education**
(2 hours with nurse and dietitian)

❑ **GROUP: Prediabetes Class**

❑ **Insulin/Other Diabetes Injectable Medication Start**
(1 hour with nurse, additional follow-up appointments as needed)

❑ **Insulin Pump Introduction and Assessment**

❑ **Advanced Carbohydrate Counting**
(1.5 hours with dietitian, 1 hour with nurse as needed)

❑ **Gestational**
(30 minutes with nurse and 1.5 hours with dietitian, additional follow-up appointments as needed)

❑ **Other Individual Nurse Diabetes Appointment**
Reason: ______________________________

❑ **Medical Nutrition Therapy with Dietitian**
Diagnosis: ____________________________

Referring Provider's signature (required): ______________________________

Referring Provider's phone: ________________ Date: ________________

This referral is valid for one year from the date signed. Please call (937) 396-8137 with any questions.