# Liberty Hospital Diabetes Education/Management
# Physician Referral Form

Patient Sticker

Today's Date: ___-___-____ Patient's Name:_____

SS#_ _ _-_ _ _-_ _ _ _ DOB: _ _-_ _-_ _ _ _ Phone #(_ _ _) _ _ _- _ _ _ _ Health Ins:_____

| **Diabetes Diagnosis:** | **Indicate one or more reasons for referral:** |
|---|---|
| ☐ Type 1, controlled<br>☐ Type 1, uncontrolled<br>☐ Type 2, controlled<br>☐ Type 2, uncontrolled<br>☐ Gestational<br>☐ Pre-Existing DM w/ Pregnancy<br>☐ Pre-Diabetes | ☐ Elevated Blood Glucose Levels<br>☐ Hypoglycemia<br>☐ Change in DM treatment regimen<br>☐ High risk due to Diabetes Complications/Co-morbid conditions:<br>o Retinopathy<br>o Hypertension<br>o Neuropathy<br>o Nephropathy<br>o Gastroparesis<br>o Hyperlipidemia<br>o Cardiovascular disease<br>o Other _____ |
| **Educational Needs:** | **Indicate any existing barriers requiring customized training:** |
| ☐ Comprehensive Self-Management (Individual sessions 1-2 hour increments)<br>☐ Comprehensive Self-Management (Group session 6-hour class)<br>☐ Insulin Instruction (individual )<br>☐ Blood glucose monitoring (individual session)<br>☐ Insulin pump instruction/management<br>☐ Continuous Glucose Monitoring training<br>☐ Management of Diabetes Pre-Conception Planning/during Pregnancy/Gestational<br>☐ Basic Nutrition Management<br>☐ Medical Nutrition Therapy (MNT) | ☐ Impaired mobility<br>☐ Impaired dexterity<br>☐ Learning disability<br>☐ Impaired vision<br>☐ Impaired hearing<br>☐ Impaired mental status/cognition<br>☐ Language barrier<br>☐ Eating disorder<br>☐ Other (please specify)_____<br>_____ |

**Physician's Signature (Required):** **Physician's Name (Printed):**

_____ _____

**Please Fax completed form to Patient Scheduling at: 816-792-7149**
**Or Call 816-792-7267 for more information.**

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