Liberty Hospital Diabetes Education/Management
Physician Referral Form

Today’s Date: ___-___-____ Patient’s Name:_________________________________________

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

### Diabetes Diagnosis:
- [ ] Type 1, controlled
- [ ] Type 1, uncontrolled
- [ ] Type 2, controlled
- [ ] Type 2, uncontrolled
- [ ] Gestational
- [ ] Pre-Existing DM w/ Pregnancy
- [ ] Pre-Diabetes

### Indicate one or more reasons for referral:
- [ ] Elevated Blood Glucose Levels
- [ ] Hypoglycemia
- [ ] Change in DM treatment regimen
- [ ] High risk due to Diabetes Complications/Co-morbid conditions:
  - [ ] Retinopathy
  - [ ] Hypertension
  - [ ] Neuropathy
  - [ ] Nephropathy
  - [ ] Gastroparesis
  - [ ] Hyperlipidemia
  - [ ] Cardiovascular disease
  - [ ] Other ____________________

### Educational Needs:
- [ ] Comprehensive Self-Management (Individual sessions 1-2 hour increments)
- [ ] Comprehensive Self-Management (Group session 6-hour class)
- [ ] Insulin Instruction (individual)
- [ ] Blood glucose monitoring (individual session)
- [ ] Insulin pump instruction/management
- [ ] Continuous Glucose Monitoring training
- [ ] Management of Diabetes Pre-Conception Planning/during Pregnancy/Gestational
- [ ] Basic Nutrition Management
- [ ] Medical Nutrition Therapy (MNT)

### Indicate any existing barriers requiring customized training:
- [ ] Impaired mobility
- [ ] Impaired dexterity
- [ ] Learning disability
- [ ] Impaired vision
- [ ] Impaired hearing
- [ ] Impaired mental status/cognition
- [ ] Language barrier
- [ ] Eating disorder
- [ ] Other (please specify)_________________________________

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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