

<i>MD Office Only</i>	
Referral Date:	_____
Insurance:	_____
Authorizations Required?	Yes No
Authorization #	_____
<i>Diabetes Center Use Only:</i>	
Auth Form not rcvd	_____
Appointment Date/Time:	_____

Physician Referral

Please **complete and sign** form and **FAX to Diabetes Center:**

Patient Name _____	DOB _____
Address _____	Telephone (H) _____
_____	Telephone (W) _____
Referring Physician _____	Telephone (Cell) _____
Address: _____	Telephone _____
	FAX _____

Check area(s) of education needed:

- Comprehensive **Self-Managing Diabetes (SMD) Classes** Group setting for Type 2
- Diabetes Overview
 - Self blood glucose monitoring
 - Nutrition management
 - Physical Activity
 - Prevention and treatment of complications
 - Psychosocial adjustment
 - Medication action, timing & side effects
 - Risk Reduction

- Comprehensive Self Management Skills (individual sessions for Type 1 or special needs)
- Medical Nutritional Therapy (MNT) Education Follow-up
- Insulin Administration Instruction Insulin Management
- Insulin Pump Continuous Glucose Monitoring

Special Needs:	
<input type="checkbox"/> Hearing	<input type="checkbox"/> Vision
<input type="checkbox"/> Language _____	
<input type="checkbox"/> Other _____	

PERTINENT DIABETES INFORMATION

Date of Diagnosis: _____ Type 1 Type 2
 New Diagnosis Diabetes out of control

Medications: None

Oral _____

Insulin _____

Complications:

None Retinopathy Neuropathy

Nephropathy Other: _____

History Of:

HTN ASHD Dyslipidemia Gastroparesis

Other _____

LAB RESULTS:

Complete or fax most recent lab work with this referral.

Date Lab work completed _____

Glucose: Fasting Glucose _____ **A1C** _____ %

Total Cholesterol: _____ **HDL** _____

LDL _____ **Triglycerides** _____

Creatinine _____

Urine Microalbumin: Negative Positive

Comments: _____

PLEASE SIGN AND DATE

I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management.



Signature of Physician: _____ **Date** _____

Please Fax completed form to the Alta Bates Summit Diabetes Center at 510-644-0891