Diabetes Self Management Program
REFERRAL FORM

Patient's name: _____ SS#: _____ Health Insurance_____

DOB: _____Phone #:_____Today's Date: _____

Diabetes Diagnosis:
☐Type1, controlled ☐ ☐Type1, uncontrolled ☐ ☐Type 2, controlled ☐ ☐Type 2, uncontrolled
☐Gestational ☐ ☐Pre-Existing DM with Pregnancy ☐ ☐Pre-diabetes

Current Treatment:
☐Diet & Exercise ☐ ☐Oral Agents: _____ ☐ ☐Insulin _____

Indicate one or more reason for referral:
☐Recurrent elevated blood glucose levels
☐Recurrent Hypoglycemia ☐
☐Change in DM treatment regimen ☐
☐High risk due to Diabetes Complications/Co-morbid conditions:
☐ ☐Retinopathy ☐ ☐Neuropathy ☐ ☐Nephropathy ☐☐Gastroparesis ☐☐Hyperlipidemia
☐ ☐Hypertension ☐☐Cardiovascular disease ☐☐Other _____

Height_____ Weight_____ Blood Pressure: _____

Recent Labs:
☐ **F**BG _____ Date: _____
☐ HgbA1C _____ Date: _____
☐ Micro-albumin_____ Date: _____
☐ Total Cholesterol: _____ Date:_____
☐ HDL _____ Date: _____
☐ LDL: _____ Date: _____
☐ Triglycerides: _____ Date: _____

Education Needed:
☑Comprehensive Self-Management skills ☐
☐Insulin Instruction ☐ ☐
☐Medical Nutrition Therapy (MNT) ☐Self blood glucose monitoring ☐
☐Management of Diabetes during Pregnancy/Gestational Diabetes Education ☐

Indicate any existing barriers requiring customized education:
☐Impaired mobility ☐ ☐Impaired vision ☐ ☐Impaired hearing ☐ ☐Impaired dexterity ☐
☐Language barrier ☐ ☐Impaired mental status/cognition ☐Eating disorder
☐Learning disability (please specify): _____
☐Other (please specify): _____

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

Provider's Signature: (Required) _____
Provider's Name (Printed): ___ _____
Telephone_____

Johnston County Health Department
Fax Referral Form to: (919) 989-5279
Questions: (919) 989-5200