Community Diabetes Education * 215 N. Fresno St. Suite 230, CA 93701
Phone: (559) 459-1763 * Fax: (559) 459-1034

COMMUNITY MEDICAL CENTERS

(To assure prompt scheduling, all sections of referral form must be completed)

Contact Person:_____ Phone # _____Fax # _____

Referring Physician _____ Primary Physician (if different) _____

Patient's
Name: **Last** _____ **First** _____ **DOB** _____ **Language:(preferred)** _____

SSN #_____

Address: _____ Apt #_____ City: _____ State:_____ Zip _____

Primary Phone # (_____) _____ Cell Phone #: (_____) _____

***Please FAX a copy of the patient's insurance card / demographic / HMO / Authorization forms and referrals**

Name of Insurance: Primary:_____ Secondary: _____

***POS, EO, PPO Insurance(s): Covered benefit of education classes**	☐ **Yes**	☐ **No (Please mark box)**
INTERPLAN, TRICARE, CCS: Authorization Form Attached	☐ **Yes**	☐ **No**
HMO Referral Attached:	☐ **Yes**	☐ **No**

Indicate any barriers to group learning, requiring 1:1 education: check all that apply

☐ Impaired vision ☐ Impaired mobility ☐ Impaired hearing
☐ Language barrier ☐ Learning difficulty ☐ Impaired mental status / cognition
☐ Eating Disorder ☐ 1:1 Insulin Training ☐ Other_____

DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES)
MEDICAL NUTRITION THERAPY (MNT)

☐ Initial Comprehensive DSMT: 10 hours *
☐ DSMES: Follow-up (2 hrs) *
☐ Medical Nutrition Therapy (MNT) initial – 3 hrs**
☐ MNT: Follow up (2 hrs)**
☐ Specific Topics and Hours if needs vary from above: _____

_____

*** DSMES can be ordered by an MD, DO or midlevel provider managing the patient's diabetes**
**** MNT must be ordered by MD or DO, is a covered Medicare benefit**

Diagnosis

☐ Type 1 DM controlled ☐ Type 1 DM, uncontrolled
☐ Type 2 DM controlled ☐ Type 2 DM, uncontrolled
☐ Pre-conception counseling ICD 10: _____

Please attach the following labs report with the referral:
A1C (within 3 month) required prior to referral
Labs: within the past 12 months: Lipid Panel / Microalbumin

Labs will be ordered for: A1c*, Lipid Panel and Microablumin if not sent with referral
*A1c will be repeated while enrolled in DSMES Program

DIABETES IN PREGNANCY PROGRAM
(Includes education and treatment under protocols)

Pre-Existing DM with Pregnancy

☐ Diabetes, Type 1
☐ Diabetes, Type 2

☐ Pre-Diabetes (prior to pregnancy)
☐ Gestational Diabetes

Labs Required

A1c _____ Date: _____
50 gm GTT Results _____ Date: _____
Fasting Glucose_____ Date: _____
Random Glucose_____ Date: _____

100 gm (3 hrs) or 75 gm (2 hrs) GTT Date: _____

Fasting_____ (95/92)
1 hour _____ (180)
2 hour _____ (155/153)
3 hour _____ (140)

EDD (Required) _____

Adapted from the American Diabetes Association Education Recognition Program, 2016

Physician Signature **(Required)** _____ Date:_____

Community Diabetes Center
Physician Referral and Order Form