

## Diabetes Education

Fax 504.903.1605

Patient Label/Stamp

Referral from:  BMC  EKL  LJC  LAK  
 LIH  UMC  WOM  Other: \_\_\_\_\_

Attending Provider: \_\_\_\_\_ ID Number: \_\_\_\_\_

*If Patient Label/Stamp is Not Available Complete the Following:*

Patient's Name: \_\_\_\_\_ Date of Referral: \_\_\_/\_\_\_/\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Medical Record Number: \_\_\_\_\_

1° Contact Number: \_\_\_\_\_ 2° Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please check all that apply:  Inpatient  Outpatient  
 New Onset Diabetes  Poor Glycemic Control  Change in Treatment Plan  
 250.01 Type I DM  250.02 Type II DM  790.22 Impaired Glucose Tolerance  
 Obstetrics 648.0 (DM)  Obstetrics 648.8 (Impaired Glucose Tolerance)

Please indicate needed Services: V65.4

Diabetes Self Management Education Program  Glucose Monitor Instruction  
 Instruction on Insulin administration  
 Nutrition:  General  Meal Planning  Carbohydrate Counting

### All of the following labs MUST be done prior to referral:

Date: \_\_\_/\_\_\_/\_\_\_ Blood pressure: \_\_\_/\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
HgbA1C (within 3 months) Date: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_\_\_  
Urine Microalbumin Date: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_\_\_  
Microalbumin/creatinine ratio (within the year) Date: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_\_\_  
Serum creatinine (within 6 months) Date: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_\_\_  
Lipids (within 6 months) Date: \_\_\_/\_\_\_/\_\_\_ LDL: \_\_\_\_\_ HDL: \_\_\_\_\_  
Total Cholesterol: \_\_\_\_\_ Triglycerides: \_\_\_\_\_  
Date of Completed Vaccinations: Flu: \_\_\_/\_\_\_/\_\_\_ Pneumovax: \_\_\_/\_\_\_/\_\_\_

List all Medications: \_\_\_\_\_

Clinical History Relevant to this Referral: \_\_\_\_\_

\*\*\*\*\*Please Send Copies of all Labs with Patient if not available at MCL/CLIQ\*\*\*\*\*

Referring Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Referring Service/Clinic: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

OFFICE USE ONLY: Appointment Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_:\_\_\_ am/pm.

If not scheduled, Indicate Reason & Recommendation: \_\_\_\_\_

Reviewing Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Rev 2/19/09