Trident Health System
Trident Medical Center | Summerville Medical Center | Moncks Corner Medical Center
Better For You™

Physician Referral Form:
Fax completed referral form and labs to: (843) 847-4943
To schedule appointment: (843) 847-4397

TRIDENT DIABETES EDUCATION -- OUTPATIENT

Patient Name_____ M / F____ DOB_____ SSN_____
Address_____ City_____ State_____ Zip_____
Home #_____ Cell #_____ Work #_____
Insurance_____ ID #_____ Medicare HICN#_____

Diagnosis: (Please send recent labs for outcomes evaluation)

_____ Type 2 Diabetes -- Controlled **(250.00)**
_____ Type 1 Diabetes -- Controlled **(250.01)**
_____ Pregnancy -- Pre-existing DM **(648.00)**
_____ Impaired Fasting Glucose -- IFG **(790.21)**
_____ Other Abnormal Glucose **(790.29)**
_____ Type 2 Diabetes -- Uncontrolled **(250.02)**
_____ Type 1 Diabetes -- Uncontrolled **(250.03)**
_____ Pregnancy -- Gestational Diabetes **(648.80)**
_____ Impaired Glucose Tolerance Test **(790.22)**
_____ Hypoglycemia unspecified **(251.2)**

New Diagnosis:
_____FBS >126 mg/dL x 2 _____2 hour post OGTT >200 mg/dL _____Random 200 mg/dL + s/sx _____A1C >6.5%

Established Diabetes: _____ Two A1c > 8.5% (3 months apart) _____ Documented complication / comorbidities:

_____ HTN
_____ Dyslipidemia
_____ Stroke
_____ Neuropathy
_____ Nephropathy
_____ Renal Disease
_____ Retinopathy
_____ Pregnancy
_____ Non healing wound
_____ PVD
_____ CHD
_____ Obesity
_____ Mental / Affective Disorder
_____ Other

*****Important Note: Insurance may refuse to pay for diabetes education if the above criteria are not followed.***

Patient Behavioral Goals: _____

Current/Desired Clinical Outcomes: A1c_____ BP_____mmHg BMI_____ Weight_____
Cholesterol_____ LDL_____ HDL_____ Trig_____

Diabetes Medications (specify type, dose, frequency):
Oral:_____
Insulin:_____

Diabetes Self Management Training (DSMT) (check type of education services being ordered):

_____ **Complete DSMT Program (10 hours Total)** -- Assessment / Plan / Intervention / Follow-up
_____ Initial Assessment **(1/2 hour**) -- Required by the ADA, prior to class attendance
_____ Diabetes Disease Process **(2 hours)** -- Overview of Diabetes, Goal Setting, and Stress Management
_____ Nutrition Management--MNT **(2 hours**) -- Carb. Counting, Fats / Cholesterol, Sodium, Portion Control
_____ Monitoring Blood Sugars & Exercise (**2 hours**) -- Monitoring blood sugars, A1c, BP, Exercise
_____ Medications & Complications (**2 hours**) -- Oral and Insulin medications, Complications, Risk Reduction
_____ 3 month follow-up (**1/2 hour**) -- Evaluate patients A1c level, Blood Sugars, BMI, Medications
_____ **Continuing Education** - 2 hours/calendar year of F/U education as indicated by physician
_____ **Insulin Instruction (type / dosage)**_____
_____ **Diabetes In Pregnancy (1-2 hours) -- Nutritional Management, Glucose monitoring, Exercise**

Patient requires: _____ DSMT -- **GROUP** instruction _____ DSMT -- **INDIVIDUAL** instruction

Patient has special need(s) to receive individual instruction (check all that apply):
_____ Vision _____ Hearing _____ Physicial _____ Cognitive Impairment _____ Language

Request to have the following sent to physicians office:
_____ Summary of Diabetes classes completed
_____ All Diabetes Education notes on patient

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

Physician Signature:_____ **Date**_____ **Phone #:**_____

Thank You For This Referral

TMC * Diabetes Ed. Dept * 9302 Medical Plaza Dr.--Suite A * Charleston, SC 29406 * Office: (843) 847-5000 * Fax: (843) 847-5017

*Created: December 2007 * Revised: 2008 , 2009, 4/2010, 5/2010