DIABETES EDUCATION – AMBULATORY

Referral Form

Fax completed form to **410-367-2042** along with **last progress note, medication list, & most recent labs including A1C**

Patient Name	
DOB	
Phone Number	

Priority		Urgent (< 3 days)		Soon (< 3 weeks)		Routine (next available)

What type of DSMT does the patient need		Is the patient taking insulin?	
Initial Comprehensive Diabetes Self-Management Training (DSMT) – 10 hours and all 9 topics		Yes, please assess and provide training if needed	
DSMT: Follow-up – 2 hours		No	
Specific Topics and Hours (if needs vary from above): ____			

Indicate any other barriers to group learning or additional insulin training requiring 1:1 education.					
Impaired mobility		Impaired Vision		Impaired hearing	
Impaired dexterity		Impaired mental status/cognition		Language barrier	
Eating disorder		Learning disability or other (please specify):			

What is the diagnosis?					
Type 2 Diabetes with hyperglycemia E11.65		Type 1 Diabetes with hyperglycemia E10.65		With long-term insulin use Z79.4	
Pre-existing Type 1 DM in Pregnancy O24.019		Pre-existing Type 2 DM in Pregnancy O24.119		Gestational Diabetes O24.419	
Other Diabetes Diagnosis (5-character Diagnosis code required) Learning disability or other (please specify):					

Provider Name (Printed)		**Practice Name**	
Provider Signature		**Provider NPI**	
Provider Phone		**Date**	

If you have any questions, please call **443-927-2749.**