

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)
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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**.