Ascension

Diabetes Education Referral

Ascension Saint Agnes

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Gender: _____

Phone (H): _____

Phone (C): _____

Address: _____

City, State, Zip: _____

Health Insurance:_____

DIAGNOSIS (CHECK ALL THAT APPLY):

☐ Type 1 Diabetes
☐ Controlled ☐ Uncontrolled

☐ Type 2 Diabetes
☐ Controlled ☐ Uncontrolled

LIST DIABETES MEDICATIONS:

Oral: _____

Injected: _____

NEEDED EDUCATION: (CHECK ALL THAT APPLY):

Diabetes Self-Management Training (DSMT)
☐ Initial ☐ Follow-up

Medical Nutrition Therapy (MNT)
☐ Initial ☐ Follow-up

REASON FOR EDUCATION:

☐ New Diagnosis ☐ Needs Review

☐ Change in treatment plan

☐ Other_____

OTHER INFORMATION:

Most recent A1C: _____ Date: _____

Language if not fluent in English:
_____

Complications:
_____

Other Pertinent Diagnoses:
_____

Barriers to Learning (Required for Medicare Patients):
_____

Physician comments to Educator:
_____

_____

REFERRING PHYSICIAN:

Referral/Order is valid 12 months from the date of physician signature.

_____

Physician Signature and UPIN#:

Date of Referral: _____

Physician Name (Print): _____

Phone: _____

Fax: _____

Fax Completed Referral to: 443-708-9355

Ascension Saint Agnes Diabetes Education Program