LALLIE KEMP DIABETES SELF MANAGEMENT EDUCATION REFERRAL FORM

PATIENT NAME _____
DOB _____
SSN _____
MED RECORD # _____
PHONE _____
ADDRESS _____
_____

PLEASE ATTACH:
COPY OF INSURANCE INFORMATION _____
SIGNED LKRMC CONSENT _____

REFERRAL DATE _____
SPECIALTY_____
CLINIC NAME_____
PROVIDER NAME_____

INDICATE REASON FOR REFERRAL
___ **Diabetes Mellitus: New Onset**
___ **Diabetes Mellitus: Type 1**
___ **Diabetes Mellitus: Type 2**
___ **Treatment Plan Change**
___ **Poor Glycemic Control**
___ **Gestational Diabetes**

NEEDED SERVICES
___ **Diabetes Education Initial Group (up to 10 hours) ___ hours**
___ **Diabetes Education Follow-Up Group (up to 2 hours) ___ hours**
___ **Diabetes Education Initial Individual (up to 10 hours) ___ hours**
___ **Diabetes Education Follow-Up Individual (up to 2 hours) ___ hours**
Reason for Individual Education
___ **Poor Vision** ___**Poor Hearing** ___ **Language Barrier** ___ **Cognitive Issues**

TOPICS TO BE COVERED
___**Comprehensive Diabetes Training Program** ___ **Monitoring Diabetes** ___ **Psychological Adjustment**
___ **Nutritional Management** ___ **Medications** ___ **Preconceptions/Pregnancy Management or GDM**
___ **Diabetes Disease Process** ___ **Physical Activity** ___ **Goal Setting and Problem Solving**
___ **Prevention, Treatment and Acute and/or Chronic Complications**

CLINICAL HISTORY RELEVANT TO THIS REFERRAL*

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***PLEASE INCLUDE MOST RECENT PCP NOTE, MEDICATION LIST, CHEMISTRY AND LIPID PANELS AND A1c IF AVAILABLE**

I certify by my signature on this orders/referral that I am managing this patient's diabetic condition and the training described in this order/plan of care is needed to ensure therapy compliance and/or provide the patient with the skills and knowledge to help manage the patient's diabetes.

ASSOCIATED DIAGNOSIS (ES) _____
REFERRING PROVIDER_____ **CONTACT NUMBER** _____
DATE/TIME OF REFERRAL_____