St. Francis Columbus Clinic

A Department of St. Francis Hospital

St. Francis Health Matters Diabetes Self-Management & Nutrition Counseling Program Referral

Patient's Name (Print): _____ SS# _____

Patient's Address (Print): _____ City: _____State: _____ Zip: _____

D.O.B.: _____ Phone #: _____ Today's date: _____

Diabetes Diagnosis: Check diagnosis criteria:

- ☐ E11.9 Type 2
- ☐ E11.65 Type 2
- ☐ Other _____
- ☐ E11.65 Type 2 – uncontrolled
- ☐ E10.65 Type 1 -uncontrolled
- ☐ O24.410 – Gestational Diabetes
- ☐ 024.11- Pre-existing Diabetes with Pregnancy
- ☐ Other_____

Known Diabetes Related Conditions:

- ☐ Newly Diagnosed Diabetes
- ☐ **Recurrent elevated blood glucose levels** List HgbA1c results _____% and date_____
  (HgbA1c >8% or fasting glucose >140 mg/dl &/or random glucose >180 mg/dl)
- ☐ Nephropathy
- ☐ Recurrent hypoglycemia
- ☐ Neuropathy
- ☐ Hypertension
- ☐ Change from oral to insulin therapy
- ☐ Retinopathy
- ☐ ESRD
- ☐ Gastroparesis
- ☐ Cardiovascular Disease
- ☐ Other: _____

Management Plan of Care: (√) CHECK training ordered:

- ☐ Comprehensive Diabetes Self-Management Training Class (ADA Certified Program)
- ☐ Pre-Diabetes Training (Community offering monthly): A1C / FPG:_____%_____mg/dl
- ☐ Nutrition Consultation – ***Please indicate the ICD10 Code:*** _____
- ☐ Insulin Instruction (instruction on how to give insulin injections) – Pt. to bring supplies to appointment – ***indicate orders below:***
  Insulin type: _____ Dose: _____ Time of day Pt. to administer insulin: _____

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  Insulin delivery via: □ Vial & Syringe □ Insulin Pen □ Insulin Pump
  □ Injectable Diabetes Medication Instruction: □ Byetta □ Bydureon □ Tanzeum □ Trulicity □ Victoza □ Other
  Administration dose/instruction:_____
  - □ Advanced Carbohydrate Counting
  - □ Self-Blood Glucose Monitoring – list frequency of testing: _____

Individualized training is indicated due to (check all that apply):

- ☐ Visual Impairment
- ☐ Impaired mental/psychosocial status
- ☐ Impaired Dexterity
- ☐ Hearing Impairment
- ☐ Learning Disability (list if known): _____
- ☐ Non-English Speaking – list patient's language:_____

Physician Signature: _____ Date: _____

Physician Name (Print): _____ Phone: _____Fax: _____

Fax completed referral form, lab reports and insurance information to:
706-243-0642 - Attn: St. Francis Health Matters Diabetes Program