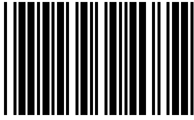
OAT

GARRETT REGIONAL
MEDICAL CENTER

DIABETES SERVICES REFERRAL

FAX TO 301-533-4673

Patient Name: ____

Patient DOB: ____

Phone number to reach patient: ____

Reason for consultation:

_______Prediabetes ____Insulin pump start/management

_______New onset diabetes _____Frequent or severe hypoglycemia

_______Type I Diabetes _______Complications of diabetes (explain)__________________

_______Type 2 Diabetes Continuous Glucose Monitor:

_______Gestational Diabetes _______Professional ________Personal

____________ **Diagnosis code: MUST HAVE!** **<u>Highest Level of Specificity Required</u>**

_______**Initial training 10 hours/ first year** _______**Follow-up training 2 hours/year**

Topics to be covered:

_______Disease overview _______Heart health _______Exercise/weight loss

_______Glucose testing _______Stress and Lifestyles _______Insulin use and effects

_______Carb counting/food record _______Meal planning/food choices

Please supply any relevant clinical information and lab work:

HbA1c: _____________ Date:_______ Glucose:_____________

Ketones:_____________ Labs pending: ______Yes _______No

Diabetes oral meds: ____

Insulin type and dose: ____

Group education is the standard and required by Medicare

Does your patient have barriers that would require him/her to be seen individually rather than in a group class? (Check and specify ICD-10 Code)

_______Vision _______Hearing _______Cognitive _______Language

_______Physical challenge _______Other (specify)____________________________

Provider Signature: ____________________________________ Date:_____-_____-20_____ Time: _____