OAT

WVU Medicine
GARRETT REGIONAL MEDICAL CENTER

DIABETES SERVICES

REFERRAL FAX TO 301-533-4175

Patient Name: _____

Patient DOB: _____

Phone number to reach patient: _____

Reason for consultation:

_____Prediabetes

_____New onset diabetes

_____Type I Diabetes

_____Type 2 Diabetes

_____Gestational Diabetes

____Insulin pump start/management

____Frequent or severe hypoglycemia

_____Complications of diabetes (explain)_____

Continuous Glucose Monitor:

_____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: _____