WVUMedicine

GARRETT REGIONAL
MEDICAL CENTER

DIABETES SERVICES REFERRAL

FAX TO: 240-226-7717

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!** **Highest Level of Specificity Required**

_____**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 1cd-10 Code)

_____Vision _____Hearing _____Cognitive _____Language
_____Physical challenge _____Other (specify)_____++_____

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