Deaconess Diabetes Center
4550 W. Lloyd Expressway • Evansville, IN 47712
Phone # 812/450-6300 • Fax # 812/450-6310

Diabetes Outpatient Educational Services

HOSPITAL STAFF: When complete, please fax ***face sheet*** and referral form **(450-6310).** Must have **Diagnosis** and **Plan of Care** marked with **Physician Signature** in order for patient to be scheduled.
PHYSICIAN OFFICE: Please complete form in entirety and fax **(450-6310).**

Patient Name: _____ **Date of Birth:** _____

Address: _____

Home Phone: _____ **Other Phone:** _____

Name of Insurance Carrier(s):_____

DIAGNOSIS

(ICD-9 Code):

- ☐ **250.00 Type 2 controlled**
- ☐ **250.01 Type 1 controlled**
- ☐ **250.02 Type 2 uncontrolled**
- ☐ **250.03 Type 1 uncontrolled**
- ☐ **Other:** _____

Complications:

- ☐ Foot Problem
- ☐ Neuropathy
- ☐ Frequent Hypoglycemia
- ☐ Retinopathy
- ☐ Hyperlipidemia
- ☐ Vascular Disease
- ☐ Nephropathy
- ☐ Hypertension
- ☐ Other: _____

PLAN OF CARE: I AM REFERRING THIS PATIENT FOR*:**

- ☐ DIABETES SELF-MANAGEMENT TRAINING – 10 hours - includes monitoring, meal planning, and follow-up sessions. Class hours may be adapted to individual needs and insurance coverage.
- ☐ INSULIN TEACHING – 2 hours:
  Type: _____ **Dose:** _____ **Time of Day:** _____
  Is patient to continue oral medication(s) ☐ YES ☐ NO
- ☐ INSULIN PUMP TRAINING – 6 hours – includes carb counting, pump start & follow-up sessions
- ☐ CONTINUOUS GLUCOSE MONITORING SYSTEM – 1 hour – includes starting & discontinuing CGMS
- ☐ PRE-DIABETES (impaired glucose tolerance)– 3 hours – for individuals without diabetes
- ☐ REVIEW OF DSMT – 2 hours – provides an update/review for someone who has completed a comprehensive program 12 months previously
- ☐ OTHER _____

*****If the patient experiences hypoglycemia, treat according to Center's protocol.*****

- ☐ Please provide individual education sessions as patient is unable to benefit from group classes due to severe impairment of sight, speech, language, or hearing; cognitive, physical or emotional limitations. (Please circle appropriate descriptor.)

Physician Signature: _____ **Physician Printed Name:** _____ **Date:** _____

Please FAX a copy of the patient's most recent A1C, Urine Microalbumin, and Lipid Profile.