Jackson County Department of Public Health
538 Scotts Creek Road • Sylva, NC 28779
Tel: 828-586-8994 • FAX: 828-586-3493
Anna Lippard
Director

Date of Referral: _____

REFERRAL FORM FOR DIABETES SELF-MANAGEMENT EDUCATION

Patient Data:
Name: _____
DOB: _____
Phone #: _____

Required: Please attach the following
**Demographic, labs, problem, & medication lists

Diabetes Diagnosis:
- ☐ Type1 (ICD-10: E10)
- ☐ Type 2 (ICD-10: E11)
- ☐ Other Specified DM (ICD-10: E13)
- ☐ Gestational (ICD-10: O24.41)
- ☐ Pre-Existing DM, T1 with Pregnancy (ICD-10: O24.01)
- ☐ Pre-Existing DM, T2 with Pregnancy (ICD-10: O24.11) ☐
- ☐ Pre-diabetes (ICD-R73.09)

Other _____

Height: _____ Date: _____
Weight: _____ Date: _____
Blood Pressure: _____ Date: _____

Recent Hgb A1C Lab: (required)
☐HgbA1C: _____ Date: _____

Complications/Co-morbid conditions:
- ☐ Retinopathy ☐
- ☐ Neuropathy ☐
- ☐ Nephropathy ☐
- ☐ Gastroparesis ☐
- ☐ Hyperlipidemia
- ☐ Hypertension ☐
- ☐ Cardiovascular disease
- ☐ Other _____

This patient has clearance to exercise: ☐ Yes ☐ No

Indicate one or more reasons for referral:
- ☐ Newly diagnosed
- ☐ Recurrent elevated blood glucose levels
- ☐ Recurrent Hypoglycemia ☐
- ☐ Change in DM treatment regimen ☐
- ☐ High risk due to Diabetes Complications

☐**Education Needed:**
- ☐ Comprehensive Self-Management skills (group)
- ☐ Comprehensive Self-Management skills (individual)

Indicate any existing barriers requiring individual education (required for Medicare):
- ☐ Impaired mobility ☐
- ☐ Impaired vision ☐
- ☐ Impaired hearing ☐
- ☐ Impaired dexterity ☐
- ☐ Language barrier ☐
- ☐ Impaired mental status/cognition
- ☐ Eating disorder
- ☐ Learning disability (please specify): _____
- ☐ Other (please specify): _____

- ☐ Insulin Instruction
- ☐ Medical Nutrition Therapy (MNT), **physician signature required for Medicare patients**
- ☐ Self-blood glucose monitoring
- ☐ Management of Diabetes during Pregnancy/ Gestational Diabetes Education

I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management.

Provider Signature (Required) : _____ Date: _____

Provider's Name (Printed): _____

NPI: _____

Telephone: _____

For Office Use Only:
- ☐ Patient did not keep appointment
- ☐ Patient could not be reached to schedule apt.
- ☐ Patient declined to schedule appointment
- ☐ Left messages on the following dates to schedule:_____