Jackson County Department of Public Health
538 Scotts Creek Rd. Suite 100 • Sylva, NC 28779
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Shelley Carraway
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:__________________________________