University of Connecticut
Health Center
UCONN Medical Group
Diabetes Education

(Patient Identification)

## Diabetes Education Referral/ Order Form

Patient Name _____ DOB _____

Address _____

Phone: Home _____ Work _____ Cell _____

**Pertinent Lab Results:**

Fasting Blood Sugar _____ Random Blood Glucose _____ A1C _____ Microalbumin_____

Lipid Profile: HDL _____ Low Density Lipids _____ Triglyceride _____

☐ **Lab reports to be included (Diabetes test results, OGTT, A1C, and other pertinent findings)**

☐ **History and Physical to be included**

**Pertinent Diagnosis:**

☐ Type 1 Diabetes, Controlled (250.01) ☐ Impaired Glucose Tolerance (790.2) ☐ Urgent

☐ Type 1 Diabetes, Uncontrolled (250.03) ☐ Gestational Diabetes (648.83)

☐ Pre Diabetes (790.0) ☐ Type 2 Diabetes, Controlled (250.00)

☐ Pregnancy complicated by preexisting DM (648.03) Due Date: _____

☐ Type 2 Diabetes, Uncontrolled (250.02) Other: _____

**Current Medication List: (Please Check)**

☐ Oral Diabetes Agents ☐ Sensitizer ☐ Insulin ☐ Antihypertensives ☐ Lipid Agent ☐Byetta/Symlin

☐ Thyroid ☐ Hormone Replacement Therapy ☐ Chemo/steroids ☐ Over the Counter/Herbs

☐ Other: _____

**Need for Diabetes Self-Management Education:**

I certify that diabetes self-management education services are needed under a comprehensive plan for this patient's Diabetes care: (check one or more of the following reasons for patient referral)

1. ☐ **New onset diabetes**: Date of diagnosis _____
2. ☐ **New Gestational Diabetes**: GTT: FBS _____1 hr _____ 2 hr _____ 3 hr_____
   EDD: _____ Para _____
3. ☐ **A change in treatment regimen**
   - □ New diabetes medications: Name/dose _____
   - □ From oral diabetes medications to insulin
   - □ Other (equipment, pump, etc.) _____
4. **Inadequate glycemic control**
   - □ A1C _____
   - □ Episodes of severe hypoglycemia or acute hyperglycemia: _____
5. **High risk for at least one of the following documented complications:**

   ☐ Retinopathy ☐ Neuropathy ☐ Nephropathy ☐ Gastroparesis ☐ Hypertension

   ☐ Hyperlipidemia ☐ CVD ☐ Depression ☐ Other: _____
6. **Pre diabetes-** Teach: _____ Meal Planning information _____Blood Glucose Monitoring

*HCH1623*

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**Management Plan of Care:**

☐ **Diabetes Outpatient Self-Management, group series:**

_____Beginners: Adult New to Diabetes
_____Beginners: Diabetes Meal Planning and Carbohydrate counting class
_____Intermediate level Self Management Class (Parts 1,2,3,4)
_____Other:_____
_____Advanced: Intensified insulin management (Updating insulin regime, adding basal/bolus therapy)

☐ **Diabetes Outpatient Self-Management, individual instruction**

_____Nursing _____Nutrition
_____Psychosocial issues (Depression – Health Risk Behavior – Regimen Adherence)
_____Other _____

☐ **Check barrier requiring individual needs** ____INTERPRETER REQUIRED

_____Visual Impairment _____Mental/Psychosocial status _____Dexterity/Mobility
_____ Hearing Impairment
_____ Language_____(1st Language) _____Learning

☐ **Assist with insulin/Oral diabetes agents management, Intensified Insulin or Pump therapy**

☐ **Additional Orders:** _____

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Physician Signature | Date | Print Name | Phone |

**Fax to: 860-679-8359**

**Mail to: UCONN Health Center – Diabetes Program**
**263 Farmington Ave. Suite C-200**
**Farmington, CT 06030-6220**
**UCHC Phone 860-679-8359**

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**UCONN Staff/Diabetes Education Office Use: Date/Time of Class/Appointment:** _____

☐ Patient Did Not Show □ Rescheduled, Date/Time: _____ □ Patient Refused