Ashley County Medical Center

Physician Referral for

Diabetes Self-Management Training

Please Fax this Form to: 888-804-5519 • For Questions, Please Call: 870-364-0563

Patient Name: ______________________________DOB: ______________Date:___________

SSN: _________________Phone: __________________Date of Diagnosis: _______________

Physician Name: ______________________________Pre-Cert # _______________________

Diagnosis:

□ Prediabetes □ Long Term Use of Oral Medication □ Long Term Use of Insulin

□ Type 2 Diabetes **Without** Complications

□ **With** Complications ____________________
List ALL Complications Above

□ Type 1 Diabetes **Without** Complications

□ **With** Complications______________
List ALL Complications Above

□ Pre-existing Diabetes in Pregnancy # ____Weeks Pregnant □ Gestational Diabetes #____Weeks Pregnant

□ Other (Specify): ____

DIABETES EDUCATION ORDER:

□ Group Diabetic Education: Up to 10 hours (includes individual session with nurse or dietitian, as well as group classes.)

□ Individual Diabetes Education: Document reason for individual instruction:

□ Medical Nutrition Therapy (Individual Session with dietitian): Up to 3 hours with this referral

□ Insulin Instruction (individual instruction with RN/CDE) Insulin Type_______Dose______

□ Annual Follow Up (2-hours – individual or group)

□ Gestational Diabetes Education (includes individual sessions with nurse & dietitian.)

□ Other: ____

INDIVIDUAL EDUCATION: Document reason for individual instruction

□ Hearing Impaired □ Visual Impairment □ Literacy

□ English as Second Language □ Other __________________________

Lab Results

FBS:	Date:	Cholesterol:	Date:
A1C:	Date:	LDL:	Date:
B/P:	Date:	HDL:	Date:
Creatinine:	Date:	Trig:	Date:

Please list all other diagnoses: ____

Please list all Medications:____

____

An Ashley County Medical Center Representative will contact the patient once this referral is received and processed. Thank you so much for the referral.

Physician Signature:____Date:____________

Contact Shawna Hawkins, RN for any questions Shawna.hawkins@acmconline.org 364-0563
Attach copy of payer source, H & P, and list of medications if not listed.