DIABETES HEALTH CENTER
A program of Community Health Trust

REFERRAL FOR SERVICES AT THE DIABETES HEALTH CENTER

Name: _____DOB:_____ Female: □ Male: □ Phone:_____

Primary Insurance: □Medicare □Alliance □ Dignity □ Other: _____

Language:_____ PCP Name:_____ Referring Provider: _____

REASON FOR REFERRAL—Please provide the following information

□Endocrinology (takes place at DHC with virtual connection to Endocrinologist)

□ Medical Nutrition Therapy (MNT)/Nutrition Education

Please indicate if patient has any of the following needs that would preclude them from participating in group classes:

□ Visual □Hearing □Congitive □Other

□ Diabetes Self-Management Education (DSME):

□ Type 1 □ Type 2 □ Diabetes in Pregnancy (Please fax copy of prenatal records, if applicable)

New diagnosis: YES / NO If no, has the patient previously received DSME: YES / NO

Diagnosis (include any co-morbidities):

1. _____ ICD-10: _____
2. _____ ICD-10: _____
3. _____ ICD-10: _____
4. _____ ICD-10: _____

Wt:_____ Ht:_____ BMI:_____ B/P:_____

Please share any behavior goals you have discussed with your patient:

_____

*****PLEASE FAX REFERRAL WITH MOST RECENT CHART NOTE, LAB RESULTS & LIST OF MEDICATIONS*****

Referring Provider Signature: _____ **Date:**_____

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