Dignity Health.
Sequoia Hospital

170 Alameda de las Pulgas, Redwood City, CA 94062
PH: (650) 367-5213 FAX: (650) 367-5293

First and Last Name: _____

Date of Birth: _____

OUTPATIENT DIABETES CENTER PHYSICIAN REFERRAL FORM

I am referring: _____
First Name Last Name Date of Birth

Phone _____ ☐ Cell ☐ Home ☐ Work

for necessary outpatient diabetes self-management training.

Please check all of the appropriate boxes. Comment section is provided for any additional information.

Type of Diabetes: ☐ Pre-Diabetes / Metabolic Syndrome / Insulin Resistance (E88.81) ☐ Type 1 (E10.65) ☐ Type 2 (E11.65) ☐ Gestational (024.419) ☐ Pregnant Type 1 (024.91__) ☐ Pregnant Type 2 (024.93)

Treatment Plan:

☐ Sweet Success Diabetes and Pregnancy Program (Followed throughout pregnancy)
☐ Comprehensive Self-Mgmt Treatment Course (10 hours)
☐ Introduction to Diabetes Self-Mgmt (3 hours)
☐ Intensive Insulin Treatment
☐ Insulin Pump Initiation
☐ Self-Management Refresher Course (2 hours)

Individual Counseling (Please specify)

☐ Nutrition Management (1 hour)
☐ Self Blood Glucose Monitoring (1 hour)
☐ Insulin Instruction (1 hour)
☐ Complications (Acute) Instruction (1 hour)
☐ Complications (Long-term) Instruction (1 hour)

Fee for Service Programs

☐ Pre-Diabetes Course (3 hours)
☐ Pre-Diabetes Individual (1 ½ hours)
☐ Weight Loss Program
☐ Meal Planning Workshop (1 ½ hrs)
☐ Grocery Store Tour (1 ½ hrs)

Other Information:

HbA1c _____ Date: _____
Lipids: Cholesterol _____ HDL _____ LDL _____ Triglycerides _____ Date: _____
GTT (pregnant pts.): Fasting: _____ 1 HR _____ 2 HR _____ 3 HR _____ Date: _____
Diabetes Medications: _____
Other Medications: _____
Past Medical History: _____

PHYSICIAN: PLEASE CHECK ONE OR MORE OF THE FOLLOWING REASONS FOR PATIENT REFERRAL:

Uncontrolled Diabetes

☐ 1. New diagnosis
☐ 2. Recurrent hospitalization for DKA or HHNK indicating need for supplemental diabetes self-management training.
☐ 3. Recurrent elevated blood sugars (fasting glucose greater than 140mg/dL; recurrent random glucose greater than 180mg/dL; or HbA1c of greater than 8%.)
☐ 4. Recurrent hypoglycemia
☐ 5. Other: _____

Diabetes / Complications Coding

☐ Retinopathy (E11.319)
☐ Neuropathy (G99.0)
☐ Peripheral Vascular Disease (I70.209)
☐ Nephropathy (N08)
☐ Hypertension (I15.8)
☐ Hyperlipidemia (E78.__)
☐ Other
☐ Diagnosis: _____

Current factors negatively affecting patient's ability to obtain self-management skills through routine physical education.

☐ Learning Disability ☐ Visual Impairment ☐ Eating Disorders ☐ Impaired Mobility ☐ Non Adherence
☐ Impaired Mental Status ☐ Morbid Obesity ☐ Impaired Dexterity ☐ Impaired Psychosocial Status ☐ Other
☐ Language: ☐ English ☐ Other

I certify that I am managing the beneficiary's diabetes condition and the training described above in the plan of care is needed to ensure therapy compliance or to provide the beneficiary with the skills and knowledge to help manage the beneficiary's diabetes.

Time: _____ Date: _____ MD Signature: _____