ORLANDO HEALTH | Health Central Hospital

DIABETES OUTPATIENT EDUCATION PROGRAM
PATIENT REFERRAL FORM

PHONE 407.347.0672 FAX 407.347.0675

DATE:	**AGE:**	**DOB:**
PT. LAST NAME:	**PT. FIRST NAME:**	**HOME PHONE:**
ADDRESS: **CITY:** **ZIP:**		**ALT. PHONE:**
INSURANCE NAME: **INSURANCE ID NO:** **AUTHORIZATION NO:**		**INS. TEL.#**

EDUCATIONAL PRESCRIPTION:

TYPE OF EDUCATION (MAY CHOOSE MORE THAN ONE):

- ❑ COMPREHENSIVE SELF-MANAGEMENT PROGRAM: INCLUDES PATHOPHYSIOLOGY, ACUTE/CHRONIC COMPLICATIONS, MEDICATION MANAGEMENT, MONITORING NUTRITION, MEAL PLANNING, EXERCISE, AND STRESS MANAGEMENT
- ❑ INSULIN ADMINISTRATION ONLY

MODE OF DELIVERY:

COMPREHENSIVE SELF-MANAGEMENT PROGRAM WILL BE IN GROUP SETTING UNLESS PATIENT REQUIRES INDIVIDUALIZED INSTRUCTION DUE TO SPECIAL NEEDS:

- ❑ PATIENT REQUIRES INDIVIDUAL INSTRUCTION DUE TO LIMITATIONS OF:
  _____VISION _____HEARING OR _____LANGUAGE OTHER: _____

DIAGNOSIS INFORMATION:

Choose Diabetes Diagnosis

- ☐ **Type 1 Diabetes E10.9**
- ☐ **Type 2 Diabetes E11.9**
- ☐ **Gestational Diabetes O24.419**
- ☐ **Pre-existing Type 1 Diabetes in pregnancy O24.019**
- ☐ **Pre-existing Type 2 Diabetes in pregnancy O24.119**
- ☐ **Pre-diabetes R73.09 (*fasting blood glucose 100 - 125 or HbA1c 5.7 - 6.4*)**

PLEASE FAX LABS INCLUDING: FBS, $HbA1_c$, LIPIDS, URINE MICROALBUMIN

I CERTIFY THIS EDUCATIONAL PROGRAM IS MEDICALLY NECESSARY UNDER COMPREHENSIVE PLAN OF CARE.

PHYSICIAN SIGNATURE: _____
(*PERSONAL SIGNATURE REQUIRED*)

PHYSICIAN NAME PRINTED: _____

REF. COORDINATOR: _____ PHONE: _____ FAX: _____