



Community Health
Education Resource Center
St. Joseph Regional Medical Center

415 6th Street
Lewiston, Idaho 83501

Diabetes Center
Physician Referral / Order
Phone: (208) 799-5227

FAX COMPLETED FORM TO: (208) 799-6520

Patient Name: _____ D.O.B.: ____ / ____ / ____

Contact Phone () _____ Work Phone () _____

Insurance type: _____ Referring care provider: _____

1. (REQUIRED as available)	Lipid Profile (if available):
Labs: FBS _____ Date: _____	HDL _____ Date: _____
(or 2 hr. GTT) _____ Date: _____	LDL _____ Date: _____
Hgb A1c _____ Date: _____	Cholesterol _____ Date: _____
	Triglycerides _____ Date: _____
Medications: (Okay to attach to sheet) _____	
Activity /Exercise Restrictions: _____	

2. Diagnosis: (please check appropriate diagnosis)

<input type="checkbox"/> Type 1 DM, new diagnosis	<input type="checkbox"/> Pregnancy complicated by gestational diabetes
<input type="checkbox"/> Type 2 DM, new diagnosis	<input type="checkbox"/> Pregnancy, complicated by pre-existing diabetes
<input type="checkbox"/> Type 1 DM, uncontrolled	<input type="checkbox"/> Pre-diabetes
<input type="checkbox"/> Type 2 DM, uncontrolled	<input type="checkbox"/> Insulin Resistance/Metabolic Syndrome

3. Instruct Patient as follows:

<input type="checkbox"/> Diabetes self management education <i>(includes basic nutrition)</i>	<input type="checkbox"/> Comprehensive Gestational diabetes education
<input type="checkbox"/> Blood glucose monitoring	<input type="checkbox"/> Pregnancy counseling for previously diagnosed Diabetes
<input type="checkbox"/> Insulin instruction/Pump therapy <i>(contact Diabetes Center for insulin initiation form)</i>	<input type="checkbox"/> Pre-pregnancy counseling for previously diagnosed Diabetes
	<input type="checkbox"/> Other

Comments: _____

For Medicare, individual instruction (1:1) for Diabetes self management education is a covered benefit only if the patient has at least one of the following conditions present:

<input type="checkbox"/> Severe vision limitations	<input type="checkbox"/> Severe language limitations
<input type="checkbox"/> Severe hearing limitations	<input type="checkbox"/> No group session is available within 2 months of the date the training is ordered.

4. As the health care provider treating this beneficiary's diabetes, I certify that diabetes self-management training is needed under a comprehensive plan of care.

Referred by: _____ Date: _____
(Physician/NP/PA Signature)

I agree to release pertinent labs and information pertaining to my diagnosis for 1 year from today's date.

Patient Signature _____

Date _____