Person completing this form name and phone number _____ _____

Outpatient Diabetes

Education Referral Form

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Patient's name: _____ DOB: _____

Contact Phone #: _____ Specify Interpreter Needed: _____

Mailing Address: _____

Health Insurance: _____ Pre-Authorization #: _____

Dates of Authorization: _____

MD Office Contact: _____ Phone: _____ *Fax: _____

STEP 1 – DIABETES DIAGNOSIS

Diagnosis Code: _____ Narrative: _____

STEP 2 – EDUCATION NEEDED

☐ Comprehensive self management skills - includes:
1 hr RN 1:1, 9 hours of divided group sessions, 1:1 with dietitian for medical nutrition therapy (*MNT*)

☐ 1:1 Individual session with RN

☐ 1:1 Individual session with dietition - Medical Nutrition Therapy (*MNT*)

☐ Insulin Pump Instruction with trained RD/RN ☐ Continuous Blood Glucose Monitoring (*CGMS*)

☐ Sweet Moms – 1:1 individual session with RN and 1:1 individual session with RD (*up to 4 visits total*)

☐ Sweet Moms – 2 hour group session with RN and RD, follow-up appointment(s) as needed.

Weeks Gestation: _____ Due Date: _____

Existing barriers requiring customized education:

☐ Language barrier

Other specific needs: _____

STEP 3 – SCHEDULING PRIORITY

☐ Routine as scheduling allows ☐ Please see patient within _____ days if possible

STEP 4 – ■ PLEASE INCLUDE RECENT COPIES OF LABS, RELEVANT CHART NOTES AND MEDICATION LIST WITH REFERRAL.

Physician/Provider signature: _____ Today's Date: ___ / ___ / ___

Physician/Provider Name (*Printed*): _____

By signing this referral I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management.

**Required*

salemhealth.org
Phone: 503-814-6990
Fax: 503-814-6992

PATIENT LABEL

DSC 434435 (1/18)