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 #: _____ Mailing address: _____

Health Insurance: _____ Pre-Authorization #: _____

Primary Care Provider: _____

Clinic Office Contact: _____ Phone: _____ *Fax: _____

STEP 1 – DIABETES DIAGNOSIS

Diagnosis Code: _____ Narrative: _____

STEP 2 – EDUCATION NEEDED

☐ Comprehensive self management program - includes: 9 hours of divided group sessions plus 1:1 appointment with Registered Nurse CDE *(Certified Diabetes Educator)* & 1:1 appointment with Registered Dietitian.

☐ 1:1 Individual session with Registered Nurse CDE *(Certified Diabetes Educator)*

☐ 1:1 Individual session with Registered Dietitian CDE *(Certified Diabetes Educator)*

☐ Insulin Pump Instruction with trained Registered Dietitian/Registered Nurse

☐ Continuous Blood Glucose Monitoring (*CGMS*)

☐ Sweet Moms – 1:1 individual session with Registered Nurse and 1:1 individual session with Registered Dietitian (*up to 4 visits total*)

Existing barriers requiring customized education:

☐ Interpreter needed - Specify language: _____

☐ Vision/Hearing impaired ☐ Low-literacy

☐ 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 (12/18)