Diabetes & Nutrition Teaching Center of Aiken Regional Medical Centers
440 Society Hill Dr., Ste. 204, Aiken, SC 29803 Ph: 803-293-0023 FAX:803-649-6361

PHYSICIAN REFERRAL/PHYSICIAN ORDER **DATE____________**

Diabetes Education Referral:

I certify that Diabetes self-management education services are needed under a comprehensive plan for this patient's Diabetes care.

Patient Name: ____ **DOB:** ____________________

Height: _______**Weight:** _____**SS#**______________________ **Phone:** __________________________

Mailing Address: ____

____

Current Treatment: Lab Values Data (if not attached):

___Diet	FBS_________	Date________	Lipid Profile Date:	___________
___Low Sodium	HbA1c______	Date________	Cholesterol	___________
___Low Cholesterol	GTT________	Date________	Triglycerides	___________
___Diabetic Medication(s)	BP__________	Date________	HDL	___________
___Oral			LDL	___________
___Insulin				

___Permission granted to DNTC to enter patient into HbA1c study

Patient has completed a formal Diabetes education program______Yes______No

Diabetes Type: Pre-Diabetes____IGT____Type 1____Type 2____Gestational/EDD________

Reason for patient referral:

_____Newly Diagnosed_____Change in treatment_____Inadequate glycemic control
_____Change in caretaker/caretaker needs instruction_____Refresher Session

Patient Self-Management Education Needs Assessment:

_____Diabetes Self-Management Training Session (group):

*Diabetes overview	*Chronic Complications	*Stress Management
*Meal Plan/Nutrition	*Diabetic Medications	*Foot & Skin Care
*Acute Complications	*Sick Days	*Changing Habits
*Evaluating Diabetes Control	*Exercise	*Goal Setting and Evaluation

_____Individual Diabetes Self-Management Training Session Due to the Following Barrier(s):
(Please circle all that apply)

*Learning Disability	*Visual Impairment	*Impaired Dexterity
*Impaired Mental Status	*Eating Disorder	*Impaired Psychosocial Status
Other______________________	*Impaired Mobility	*Language Spoken____________

_____Blood Glucose Meter Instruction and Record Keeping (1 Session)

_____Insulin Start/Administration (1 Session)
***Insulin Type(s)________________** ***Insulin Dose__________________**

Diagnosis Code(s)/Comments____

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Physician Signature **Date**