Outpatient Diabetes Self-Management Education & Support Services Referral

Patient's Name: _____ **DOB:**_____

Primary Insurance: _____ **Secondary Insurance:** _____

Home: _____ **Cell:**_____ **Work:** _____

PHYSICIANS ORDERS

Diagnosis for Diabetes:

- ☐ **Diabetes (Type 2) ICD code:**_____
- ☐ **Diabetes (Type 1) ICD code:**_____
- ☐ **Pre-Diabetes/IFG/IGT ICD code:**_____
- ☐ **Gestational Diabetes ICD code:**_____
- ☐ **Type 1 Diabetes & Pregnancy ICD code:**_____
- ☐ **Type 2 Diabetes & Pregnancy ICD code:**_____

- ☐ **Diabetes Self-Management Education & Support Services**
- ☐ **Special Needs Diabetes Self-Management Education & Support Services:**
  Please circle any existing barriers requiring customized education: impaired mobility, impaired vision, impaired hearing, impaired mental status/cognition, learning disability (specify):_____
  Language barrier Language:_____
- ☐ **Gestational/Pregnancy with Pre-existing Diabetes Self-Management Education & Support Services**
  Due Date: _____ Current Gest Age: _____

Please provide the following information or include a copy of most recent labs:

Date: _____ **HgA1C:** _____ **% Total Chol.:** _____ **HDL:** _____ **LDL:** _____ **Trigs:** _____

Serum Creatinine: _____ **GFR:** _____

Please list:

Oral Anti-Diabetic Agent: _____

Injectable Anti-Diabetic Agent(non-insulin):_____

Insulin(s): _____

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

Referring Provider Signature	Print Name	NPI/MHHS ID.	Date	Time ☐ AM ☐ PM	Contact No.
_____	_____	_____	_____	_____	_____

Please choose which facility the patient prefers and fax form to the number indicated:

- ☐ **Memorial Hermann Katy**, Phone: 281-644-7180, Fax order to: 281-644-7012
- ☐ **Memorial Hermann Memorial City**, Phone: 713-242-3700, Fax order to: 713-242-3964
- ☐ **Memorial Hermann Sugar Land**, Phone 281-725-5050, Fax order to 281-725-5660
- ☐ **Memorial Hermann Southeast**, Phone: 281-929-6485, Fax order to: 281-929-4710
- ☐ **Memorial Hermann Southwest**, Phone: 713-456-5150, Fax order to: 713-456-5179
- ☐ **Memorial Hermann The Woodlands**, Phone: 713-897-2514, Fax order to: 713-897-2381

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