

Hillcrest Baptist Medical Center

## Diabetes Self Management Education (DSME)

Program Referral Form

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Most recent HgbA<sub>1C</sub>: \_\_\_\_\_ date drawn: \_\_\_\_\_ (a current A<sub>1C</sub> is required for enrollment)

Patient requires DSME due to (✓ all that apply)  New Onset Diabetes  Uncontrolled Diabetes

Change in Treatment Regimen  High risk for acute/chronic complications  Other: \_\_\_\_\_

Is your patient cleared for mild to moderate aerobic exercise?  Yes  No

Will the patient be able to learn effectively in a group setting?  Yes  No, this patient will require

individual training due to the following learning barrier(s):  Visual  Hearing  Language

Psychosocial  Cognitive  Other: \_\_\_\_\_

I am ordering:

The complete DSME assessment and training program (up to 10 hours)

Blood draw for 3 month follow-up Hemoglobin A<sub>1C</sub> level

Only the following education topic(s)

- Diabetes disease process/treatment options
- Understanding Diabetes Medications
- Dietary strategies/modifications (*this topic is in addition to patient's Medical Nutrition Therapy benefit*)
- Exercise: Benefits/getting started
- Monitoring: using results to improve control
- Preventing, detecting, treating acute complications
- Preventing, detecting, treating chronic complications
- Goal setting/problem solving for healthy behavior change
- Psychosocial adjustment

The following specialized training (*may be ordered solely or in addition to any of the above*)

- Insulin administration (self-injection training only)
- Assist patient with insulin dose titration
- Glucometer training (we can assist pt with obtaining a meter, if needed)
- Pre-conception care/Diabetes management during pregnancy (***if this training is requested, please specify***):  
This patient has pre-existing  Type 1 Diabetes  Type 2 Diabetes  Neither, pt has Gest DM
- Medical Nutrition Therapy (MNT) with Registered Dietitian

Printed Name of Referring Physician: \_\_\_\_\_

Office phone: \_\_\_\_\_ Office fax: \_\_\_\_\_

*I certify that I am managing this patient's condition and that the requested DSME training is needed.*

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Fax completed referral to (254) 202-5924 attn: DSME. For more information, call: (254) 202-5954