Patient Name _____

Patient MRN _____

Baylor Scott & White CLINIC
COLLEGE STATION ROCK PRAIRIE
A department of Baylor Scott & White Medical Center – College Station

Diabetes Education Referral Form

Complete and fax this form, along with patient's demographics page, to **979.207.4120.**

Referral Information (to be entered by referring physician)

Requesting Provider & Doctor Number: _____ Date of Request: _____

Reason for Referral:

❑ New onset diabetes ❑ Uncontrolled diabetes ❑ Impaired fasting glucose/impaired GTT

❑ Frequent or severe hypoglycemia ❑ Other (please specify): _____

Patient's Diabetes Diagnosis:

❑ Type 1 uncontrolled ❑ Type 1 controlled ❑ Type 2 uncontrolled ❑ Type 2 controlled

❑ Other (please specify): _____

Barriers requiring individual rather than group diabetes instruction:

❑ None ❑ Vision ❑ Hearing ❑ Language limitations ❑ Cognitive ❑ Physical challenge

❑ Other (please specify): _____

Patient Information for Class (to be entered by diabetes educator or referring physician)

Current Diabetic Medications: _____ HgbA1C & Date: _____

❑ None ❑ Oral (type & dose) _____ ❑ Insulin (type & dose) _____

❑ Frequent or severe hypoglycemia ❑ Other (please specify): _____

Current Complications or Comorbidities:

❑ None ❑ HTN ❑ Dyslipidemia ❑ Neuropathy ❑ Stroke ❑ Nephropathy ❑ Non-healing wound

❑ Obesity ❑ Retinopathy ❑ PVD ❑ CHD ❑ Affective disorder

❑ Other (please specify): _____

I certify that I am managing this patient's condition and the education described in the Plan of Care. The Plan of Care is needed to provide this patient with the skills and knowledge to help manage their diabetes.

Provider Signature: _____ Date: _____