



Outpatient Diabetes Management Program

For an appointment, please call:

Central Scheduling 281-644-7180 & Fax Referral to 281-644-7012

We will contact your patient once referral is received but please give patients the scheduling phone number also.

Thank you.

Patient's Name: _____ DOB: _____

Primary Insurance: _____ Secondary Ins.: _____

Home: _____ Cell: _____ Work: _____

Diagnosis for Diabetes: <input type="checkbox"/> Diabetes (Type 2) ICD-10 code: _____ <input type="checkbox"/> Diabetes (Type 1) ICD-10 code: _____ <input type="checkbox"/> Gestational Diabetes ICD-10 code: _____ <input type="checkbox"/> Pre-Diabetes/IFG/IGT ICD-10 code: _____	Reason for Referral: (all that apply) <input type="checkbox"/> Newly diagnosed <input type="checkbox"/> Recurrent elevated glucose levels <input type="checkbox"/> Recurrent Hypoglycemia <input type="checkbox"/> Change in DM treatment regimen <input type="checkbox"/> High risk due to DM complications
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Physician's Orders:

Diabetes Education Referrals (Includes Nutrition)

Diabetes Self-Management Program & Individual Appointments
Comprehensive program with RD

Follow up Only
Patient has previously attended one of our classes

Gestational Diabetes Management

Gestational Diabetes
 Type 1 Diabetes with Pregnancy
 Type 2 Diabetes with Pregnancy
 Due Date: _____ Current Gest Age: _____

Spanish Diabetes Self-Management Program

Insulin Education Only

Indicate any existing barriers requiring customized education:

Impaired mobility
 Impaired vision
 Impaired hearing
 Impaired mental status/cognition
 Impaired dexterity
 Learning disability (specify): _____
 Language barrier. Language: _____
 Other: _____

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

Oral Anti-Diabetic Agent: _____

Insulin(s): _____

I hereby certify that I am managing this beneficiary's Diabetes condition and that the above prescribed training is a necessary part of management. (Medicare patients)

Referring MD: _____ Phone: _____ Fax: _____

Physician's Signature: _____ Date: _____

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