

Diabetes Self-Management Education Referral Form

Date: _____

Patient's Name: _____ Social Security Number: _____

DOB: _____ Gender: M ___ F ___

Patient's Address: _____

Phone Number: _____

***Please include copy of patient's insurance card(s) (front and back)**

Diabetes Diagnosis:

- Type 1 Gestational
 Type 2 Diagnosis Code _____
Initial HbA1c: _____ Fasting Blood Glucose: _____

*** Please send office notes and recent labs for patient eligibility and outcomes monitoring**

Referral For:

- Initial Comprehensive Diabetes Self-Management Education (DSME) DSME: Follow-up

Specific Topics: _____

*DSME can be ordered by an MD, DO or midlevel provider managing the patient's diabetes.

Indicate any barriers to group learning or additional insulin training requiring 1:1 education:

- Impaired Mobility Impaired Vision Impaired Hearing Impaired Dexterity
 Impaired Mental Status Recognition Language Barrier Eating Disorder
 Learning Disability or Other (Please Specify): _____

- 1:1 Insulin Training

Clinician's Printed Name: _____

Clinician's Signature: _____ Date: _____

Group Practice Name: _____

Address: _____

Group Practice

Phone/Fax Numbers: _____

**Please fax all referrals to:
Mississippi State Department of Health
Diabetes Prevention and Control Program
Fax Number: 601-899-0154
Attention: Diabetes Program**

Diabetes Self Management Education Referral Form Form 52E

PURPOSE

The purpose of this form is to provide a method of referral for healthcare providers of clients diagnosed with diabetes to be enrolled in the Mississippi State Department of Health (MSDH) Diabetes Self-Management Education (DSME) Program.

INSTRUCTIONS

This form is to be completed on all clients referred to the MSDH DSME Program.

This form is to be completed by the referring provider. (*DSME can be ordered by an MD, DO or midlevel provider managing the patient's diabetes.

Diabetes Self-Management Education Referral Form

Date – Enter today's date.

Patient's name – Enter client's first and last name.

Patient's social security number – Enter the client's social security number.

DOB – Enter client's date of birth.

Gender – Check M for male or F for female.

Patient's Address – Enter name of street and number where client lives. Enter P.O. Box as well if applicable.

City/State/Zip Code - Enter city, state, and zip code where patient lives.

Phone number(s) – Enter phone number(s) where client can be reached.

Insurance card – Attach copy of client's insurance card, both front and back.

Diabetes Diagnosis – Check the box that applies to the type of diabetes the client has been diagnosed with.

Initial HbA1c – Enter the current HbA1c value as indicated on the client's lab report.

Fasting Blood Glucose – Enter the current fasting blood glucose value as indicated on the client's lab report.

Diagnosis Code – Enter the diagnosis code that corresponds with the client's diabetes diagnosis

Referral For – Check all that apply.

Specific Topics – Enter specific topics to be covered if applicable.

Indicate any barriers to group learning or additional insulin training requiring 1:1 education – check all that apply

Clinician's printed name and signature – Enter printed name and signature of referring physician/provider

Group Practice – Enter name of group practice of referring physician/provider

Group Practice Address – Enter address of group practice of referring physician/provider

Group Practice Phone/Fax number – Enter phone/fax numbers of group practice of referring physician/provider