

# Outpatient Diabetes Self-Management Education & Support Services Referral

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

## PHYSICIANS ORDERS

Diagnosis for Diabetes:

- |   |  |
|---|--|
| <input type="checkbox"/> Diabetes (Type 2) ICD code: _____    | <input type="checkbox"/> Gestational Diabetes ICD code: _____        |
| <input type="checkbox"/> Diabetes (Type 1) ICD code: _____    | <input type="checkbox"/> Type 1 Diabetes & Pregnancy ICD code: _____ |
| <input type="checkbox"/> Pre-Diabetes/IFG/IGT ICD code: _____ | <input type="checkbox"/> 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 <input type="checkbox"/> AM <input type="checkbox"/> 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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