

Diabetes Solutions

Request for Consultation or Referral

Physician Request For: **Consult** **Referral**

Patient Information

Name _____
 Address _____
 City/State/Zip _____
 Date of Birth _____
 Phone # _____
 Cell # _____
 Insurance Carrier and # _____

Reason for Referral

- New diagnosis
- Uncontrolled diabetes
- Gestational diabetes
- Lifestyle modifications
- Hypoglycemia or hyperglycemia
- Change in treatment regimen
- High risk for complications
- Insulin pump start
- Other _____

Lab Results (Please fill in the blank or fax copy to 785.623.5108)

HgbA1c _____ Date _____
 BMI _____ Date _____
 Microalbumin _____ Date _____
 Creatinine _____ Date _____
 LDL _____ Date _____
 HDL _____ Date _____
 Triglycerides _____ Date _____

Physician Order (mark all that apply)

- Self-Management Diabetes Program
(Two 5 hour group sessions)
- PA-C to calculate and adjust meds
- One-on-one diabetes education
- Gestational diabetes care
- Provide instructions or comments

Diabetes Medications and Doses
(please send med list)

Diagnosis

- Type 1 Diabetes
- Type 2 Diabetes
- Gestational Diabetes
- Pre-existing diabetes and pregnancy
- Pre-diabetes or impaired fasting glucose
- Metabolic Syndrome

Complications

- Hypoglycemia unawareness
- Retinopathy
- Neuropathy
- Cardiovascular disease
- Nephropathy
- Gastroparesis
- Other _____

Barriers that Impede Learning Ability

- Non-adherence
- Visual/hearing impairment
- Learning disability
- Impaired mental status
- Impaired dexterity
- Language barrier _____

Clinic _____
 Provider's Name _____
 Date _____
 Address _____
 City/State/Zip _____
 Phone # _____
 Fax # _____

Physician Signature: _____ Date/Time: _____

Please fax referral/consult to 785.623.5108. If questions, please call 855.429.7633 or 855-HAYS MED. Thank you for the referral.

Patient Label

