NORTHWEST HOSPITAL & MEDICAL CENTER
Diabetes Services
1550 North 115th Street, MS E-729
Seattle, WA 98133

Diabetes Education Referral

Phone: (206) 368-1564
Fax: (206) 368-1501

PLEASE **FAX COMPLETED** FORM TO (206) 368-1501

PATIENT INFORMATION

Name ______________________ Social Sec. # ______________________ DOB: ____________

Address ______________________ City, State, Zip Code: ______________________

Day Phone ______________ Evening Phone ______________ Insurance: ______________

Physician ______________________ Physician Phone & Fax #: ______________________

MEDICAL INFORMATION

Diagnosis: ☐ Type I ☐ Type II ☐ Gestational Diagnosis ICD-9-CM Code: ______________

Complications: ______________________ Weight: ____________ Blood Pressure: ____________

☐ **MOST RECENT LAB WORK IS ATTACHED** ☐ **LAB WORK IS AVAILABLE FROM NWH HBOC**

LAB DATA	**Date:**		**Result:**
	_________	Fasting Glucose	___________
	_________	HgbA1c	___________
	_________	Triglycerides	___________
	_________	Cholesterol	___________
	_________	LDL	___________
	_________	HDL	___________
	_________	Albuminuria	___________

MEDICATION: (Type and Dose)

____

____

____

TREATMENT PLAN

Rationale For Education:

☐ New Onset ☐ Inadequate glycemic control ☐ Change in treatment plan ☐ At risk for complications ☐ Other:____________

Education Options: (Please check appropriate boxes)

☐ **Group Education Classes** (4 sessions which include education about diet, exercise, self-monitoring of blood glucose, **medications** (oral and insulin), complications, and other self management topics). Draw a baseline HgbA1c at the beginning of the class (if not done within 1 month prior to class) and 3 months after the class.

☐ **1:1 instruction with** ☐ **Registered Nurse** ☐ **Registered Dietitian**
Recommended Diet Therapy: ______________________________

1:1 instruction is required because: (RESPONSE IS REQUIRED)

❍ Group Classes not available within 2 months.

❍ Patient has special needs: ❍ vision ❍ language ❍ hearing ❍ other: ______________________

❍ Patient needs insulin administrative teaching: ______________________________

❍ Follow-up teaching after group class

❍ Other: ______________________________________

Special Conditions or Considerations: ______________________________________

I certify that Diabetes Education is part of the comprehensive Plan of Care for this patient.

______________________ ______________________________________
Date **Physician Signature**