HAYSMED

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)
❑ One−on−one diabetes consult with Certified Diabetes Educator (CDE) in clinic
❑ Gestational diabetes care
❑ Assume care of diabetes

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−HAYSMED. Thank you for the referral.

Patient Label