REFERRAL FORM

South Central Health District
105 East Jackson Street
Dublin, GA 31021
Phone: 478-275-6545 Fax: 478-275-6575

Diabetes Self-Management Education Services/Training

Please submit demographic information and Insurance Information with this form

Patient Information:

Patient's Last Name: First Name: Middle:

Date of Birth: Gender: Male Female

Address: City State ZIP

Home Phone Cell Phone Email Address:

Diabetes Self-Management Education & Training (DSME/T)

Check number of training services and number of hours requested:

- [ ] Initial group DSME/T
- [ ] Follow-up DSME/T
- [ ] Telehealth
- [ ] 10 Hours

DSME/T Content

- [ ] Monitoring Diabetes
- [ ] Psychological Adjustment
- [ ] Nutritional Management
- [ ] Goal Setting/Problem Solving
- [ ] Prevent, detect, & treat chronic complications

OR Preconception/pregnancy management or GDM

- [ ] Diabetes as disease process
- [ ] Physical Activity
- [ ] Medications
- [ ] Prevent, detect & treat acute complications
- [ ] All of the above

Patients With Special Needs Requiring Individual (1 on 1) DSME/T

Check all special needs that apply:

- [ ] Vision
- [ ] Physical
- [ ] Language Limitations
- [ ] Additional Training
- [ ] Other: ____________
- [ ] Hearing
- [ ] Cognitive Impairment
- [ ] Telehealth
- [ ] Additional Hours Requested ____________

Complications/Comorbities (check all that apply)

- [ ] Hypertension
- [ ] Neuropathy
- [ ] Retinopathy
- [ ] Non-healing Wound
- [ ] Other: ____________
- [ ] Dyslipidemia
- [ ] Kidney Disease
- [ ] Pregnancy
- [ ] Mental/Affective Disorder
- [ ] Stroke
- [ ] PVD
- [ ] CHD
- [ ] Obesity

DIAGNOSIS: Please submit most recent A1C, Lipid Panel, & last office visit for patient eligibility outcomes monitoring

- [ ] Type I
- [ ] Type II
- [ ] Gestational

Diagnosis Code: ____________ Date: ____________

Referral Number: ____________

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Signature/NPI #