SUMMA DIABETES OUTPATIENT SERVICES REFERRAL FORM

Patient Name:_____DOB:_____
Address: _____
City: _____State: _____Zip: _____
Home Phone:_____ Other Phone:_____
Special needs for individual instruction:_____(Vision, Hearing, Language, Other)
Height:_____Weight:_____ Pre-Pregnancy Wight (if applicable): _____
Diagnosis (es) verbiage only: _____

RECENT LABS: (FILL IN OR ATTACH RECENT LABWORK)

Date:_____ HgbA1C:_____ HgbA1C Goal: _____

DIABETES SELF MANAGEMENT TRAINING/EDUCATION (DSMT/E)

☑ DEEP (Diabetes Empowerment Education Program)

☑ COMPREHENSIVE DIABETES MANAGEMENT SERVICES (UP TO 10 HOURS)* includes the National Clinical Standards and guidelines for: disease process, nutritional management, physical activity, medications for diabetes, self-monitoring, preventing acute and chronic complications, goal setting/problem solving and psychosocial adjustment

☑ ANNUAL FOLLOW-UP TO COMPREHENSIVE MANAGEMENT PROGRAM (UP TO 2 HOURS)

ADDITIONAL COMMENTS:_____

I hereby certify that I am managing this beneficiary's diabetes condition and that the above prescribed training is a necessary part of management.

Physician's Signature :(Required)_____Date:_____Time:_____
Physician's Name: (Printed)_____
Phone:_____Fax:_____

PLEASE EMAIL FORM TO:

DIABETESCENTER@SUMMAHEALTH.ORG

Phone: 234-312-6420

Summa Health™