PMSI Diabetes Education Referral

PATIENT INFORMATION

Name: _____

Address: _____

City_____ Postal Code _____

Contact Phone: _____ Other_____

Date of Birth: _____

Location Preference:

_____ Brookside _____ Boyertown

_____ Collegeville _____ Spring-Ford

This patient is recommended for **Comprehensive Diabetes Self-Management** education based on the following criteria:

_____ Type 1 controlled

_____ Type 2 controlled

_____ New Onset

_____ Type 1 uncontrolled

_____ Type 2 uncontrolled

_____ Inadequate glycemic control with variability

_____ This patient is also recommended to wear a continuous glucose monitor (CGM) to help with making decisions in treatment and assist patient with self management skills for living with diabetes..

HEALTHCARE PROVIDER INFORMATION

Name: _____

Practice: _____

Address: _____

City_____ Postal Code _____

Signature: _____

Phone:_____

Fax:_____

Insurance Information:

DIABETES EDUCATION CONTACT INFORMATION

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PLEASE PROVIDE MOST RECENT LABS, MEDICATIONS AND RECENT CHART NOTES