REFERRAL FORM
DIABETES EDUCATION

TEXAS A&M UNIVERSITY
Healthy South Texas

Name	Date of Birth	Phone
Address	City/State	Zip Code
Health Insurance	e-mail address	Alternate Phone #

Please check all that apply and Fax to (361) 561-8644

Diabetes Diagnosis:	**Reason for Referral**	**Current Treatment**
☐Type1	☐Newly Diagnosed	☐ Diet & Exercise
☐ Type 2	☐ Recurrent elevated blood glucose levels	☐ Oral Agents & Insulin
☐ Gestational	☐Recurrent Hypoglycemia	☐ Insulin
☐ Pre-Existing DM with Pregnancy	☐Change in DM treatment regimen	**Recent Labs:**
☐ Pre-diabetes	☐High risk due to Diabetes Complications/Co-morbid conditions:	HgbA1C__________________
☐ Other	☐Retinopathy	Micro-Albumin_____________
Diet	☐Neuropathy	Total Cholesterol___________
Per Health Educator	☐Nephropathy	HDL______________________
Exercise	☐Gastroparesis	LDL______________________
☐ May participate	☐Hyperlipidemia	Triglycerides: _____________
☐ May NOT participate	☐Hypertension	
	☐Cardiovascular disease	
	☐Other ________________	

Referral For: ☐ Diabetes Self-Management Education& support Training-*English*

☐ Diabetes Self-Management Education & Support Training -Spanish

Indicate any existing barriers requiring customized education:

☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing ☐ Impaired mental status/cognition

☐ Language barrier ☐ Learning disability or other (please specify): ______________________________________

Group Practice name, address ____

Referring Healthcare Provider Signature : ______________________________Phone # ______________________