Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City & ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Please check all that apply and fax with physician’s signature.**

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| --- | --- |
| **Diagnosis: Medical Status:**❒ Type 1 ❒ Newly Diagnosed❒ Type 2 ❒ New to Insulin❒ Pre-diabetes ❒ New to Oral anti-diabetes med.❒ Gestational ❒ Severe Hypo-Hyperglycemia requiring ED visits or hospitalization ❒ HbA1c ≥ 8.5, 2 consecutive times 3 or more months apart  ❒ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Complications** ❒ N/A❒ frequent hypoglycemia ❒ nephropathy❒ retinopathy ❒ neuropathy❒ vascular disease❒ foot ulcer, charcot |
| **Classes:** ❒ Gestational Diabetes Class  |
| **Diet:**❒ Per Dietitian/CDE Recommendations❒ Sodium Restriction❒ Fluid Restriction❒ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Exercise:**❒ May participate in 30 min. walking/stretching❒ May participate in stretching as tolerated❒ May not participate |
| **For Insulin Start (only):**❒ OK to instruct patient on insulin self-management.❒ Insulin (type, dose, frequency): ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Recent Results:** Pregravid weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of previous pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_GTT—Blood Glucose Levels: FBS \_\_\_\_\_\_\_\_\_\_ 1 Hr. \_\_\_\_\_\_\_\_ 2 Hr. \_\_\_\_\_\_\_\_\_ 3 Hr. \_\_\_\_\_\_\_\_\_\_Date GTT Obtained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Referring Physician** *(print)***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Physician Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |