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

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

City & ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nueces Ct Aide Pt: ❒ Yes ❒ No

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Location: ❒ Corpus Christi ❒ Cuero ❒ Kingsville ❒ Victoria

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

|  |  |
| --- | --- |
| **Diagnosis: Medical Status:**❒ Type 1 ❒ Newly Diagnosed❒ Type 2 ❒ New to Insulin❒ Pre-diabetes ❒ New to Oral anti-diabetes med.❒ Other ❒ Severe Hypo-Hyperglycemia requiring ED visits or hospitalization❒ Gestational ❒ 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:**❒ Diabetes Self-Management – 8 Hour Class ❒ Glucose Monitor Training❒ Diabetes Self-Management – 8 Hour Class (Spanish) ❒ Insulin Administration Consult❒ Diabetes Self-Management – Series of 4 Weekly (Eng./Span.) ❒ Hyperlipidemia Consult |
| **Diet:**❒ Per Dietitian/CDE Recommendations❒ Other | **Exercise:**❒ May participate in 30 min. walking/stretching❒ May participate in stretching as tolerated❒ May not participate |
| **For Insulin Administration Training (only):**❒ OK to instruct patient on insulin self-management❒ Insulin (type, dose, frequency): ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Recent Results:** Total Cholesterol \_\_\_\_\_\_\_\_ HDL \_\_\_\_\_\_\_\_ LDL \_\_\_\_\_\_\_\_ Triglycerides \_\_\_\_\_\_\_\_ HBA1c \_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(Please print)**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Physician Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |