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 # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |