Friedman Diabetes INSTITUTE Beth Israel Medical Center

Physician Referral Form

Division of Endocrinology, Friedman Diabetes Institute
Diabetes Education Program
Phone: (212) 420-3450
Fax: (212) 420-3453 (ATTN: Karina)

Patient Information
Name______________________________________ Date _____________
DOB______________________ SS#_________-______-____________
Phone#___________________

Diagnosis ☐ DM 1 ☐ Pre-existing Diabetes with pregnancy ☐ Gestational
☐ DM 2 – Diet ☐ DM 2 – Oral agent ☐ DM2 – Insulin
☐ DM 2 – Oral agents + Insulin ☐ Other ______________________

Plan of Care (please choose all that apply)
☐ Comprehensive Management Skills Group Class
☐ Comprehensive Management Skills (1:1)
☐ Nutrition Management (1:1)
☐ Self Blood Glucose Monitoring (1:1)
☐ Insulin Instructions
☐ Management during Pregnancy
☐ Acute Complications
☐ Long-Term Complications
☐ Insulin Pump Start-up

☐ **Exercise Instructions** (Stress Test (-))
☐ There are no contraindications toward participants in a fitness program
☐ I believe the applicant can participate, but urge caution because:____________________
☐ The applicant should not engage in the following activities: ______________________
☐ Other___________________

Diabetes Lab Results ☐ HbA1c _________ Date ______________ ☐ See attached
Check if you would like patient to have: ☐ HbA1c ☐ Microalbumin ☐ Lipid Profile

Medications:____
____ ☐ See attached

Reason(s) for patient referral
☐ Recurrent elevated BG levels:
☐ HbA1c > 8%
☐ Fasting BG > 140 mg/dL
☐ Random BG > 180 mg/dL
☐ Recent admission for DKA/HHNS
☐ Recurrent hypoglycemia
☐ Inappropriate utilization of diabetes services
☐ ER ☐ Home Health Service
☐ Hospital ☐ Physician Office
☐ Other_____________________________________

Diabetes Complications / Co-morbidities
☐ Retinopathy ☐ Neuropathy ☐ Nephropathy ☐ HTN
☐ CAD ☐ Dermatopathy ☐ Hyperlipidemia ☐ Gastroparesis

Barriers for training
☐ Non-adherence ☐ Morbid Obesity ☐ Impaired Mobility ☐ Visual Impairment
☐ Learning disability ☐ Eating Disorder ☐ Impaired Mental Status ☐ Hearing Impairment
☐ Impaired Psychosocial States ☐ Other ______________________________________

Language ☐ English ☐ Spanish ☐ Other _________________________

Physician's Signature ________________________ **Date** ________________________
Referring Physician Name ____________________________________ **Phone:** _________________
Fax _________________________________
Address ____
City _____________________________________ **State and Zip** _____________________

Adapted from ADA Physician Prescription form_2006