Community Diabetes Education - Pregnant Patient Diabetes Referral Form
215 N. Fresno St. Suite 230, Fresno, CA 93701
Phone: (559) 459-1763 Fax: (559) 459-1034

COMMUNITY MEDICAL CENTERS

To assure prompt scheduling, all sections of referral form must be completed

Patient Information (complete on all patients)

Patient Name: _____ DOB: _____

Patient Address: _____ City/State/Zip: _____

Patient Phone Number: Primary Phone #: (_____)_____ Cell Phone #: (_____)_____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ SSN: _____

Referring Physician (Print Name): _____ Primary Physician (if different): _____

Contact Person: _____ Phone #: _____ Fax #: _____

Please FAX a copy of the patient's insurance card / demographic / HMO / Authorization forms and referrals

Name of Insurance: Primary: _____ Secondary: _____

POS, EO, PPO Insurance(s): Covered benefit of education classes ☐ Yes ☐ No (Please mark box)
INTERPLAN, TRICARE, CCS: Authorization Form Attached ☐ Yes ☐ No
HMO Referral Attached ☐ Yes ☐ No

Indicate any barriers to group learning, requiring 1:1 education: check all that apply

☐ Impaired Vision ☐ Impaired Mobility ☐ Impaired Hearing
☐ Language Barrier ☐ Learning Difficulty ☐ Impaired Mental Status / Cognition
☐ Eating Disorder ☐ 1:1 Insulin Training ☐ Other _____
☐ N/A - No Barriers to Group Learning

Diagnosis (complete on all patients)

☐ Type 1 Diabetes Mellitus (DM)
☐ Type 2 Diabetes Mellitus (DM)
☐ Pre-Diabetes (prior to pregnancy)
☐ Gestational Diabetes
☐ Other Diabetes Diagnosis – ICD10: _____

Estimated Due Date (required): _____

Scheduling Priority:
☐ Participant's Preference (1–3 Weeks)
☐ Standard Protocol (1 Week)
☐ Urgent (1–3 Days)

Diabetes Self-Management Training
(check requested service below)

☐ Diabetes Self-Management Training (DSMT) & Initial Medical Nutritional Therapy (MNT)**
☐ Diabetes Self-Management Training (DSMT)*
☐ Medical Nutrition Therapy (MNT) ••
☐ Specific topics and hours if needs vary from above: _____

_____

*** DSMT can be ordered by an MD, DO, or midlevel provider managing the patient's diabetes**
**** MNT must be ordered by an MD or DO**

Labs Required (please fax with referral)

A1C _____ Date _____
50 gm GTT Result _____ Date _____
Fasting Glucose _____ Date _____
Random Glucose _____ Date _____

100 gm (3 hrs) or 75 gm (2 hrs) GTT Date _____

Fasting _____ (95/92)
1 Hour _____ (180)
2 Hour _____ (155/153)
3 Hour _____ (140)

Adapted from the American Diabetes Association Education Recognition Program

Date/Time: _____ Physician Signature: _____ Physician ID#: _____

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