2500

PROVIDENCE Health & Services

Outpatient Referral Form

Providence Diabetes Health and Wellness Education—Oregon

PATIENT LEGAL NAME	DATE OF BIRTH	PATIENT PHONE: H, W, C
INSURANCE NAME	MEMBER/POLICY ID#	
PHYSICIAN NAME	PHYSICIAN PHONE	PHYSICIAN FAX
SYMPTOMS/DIAGNOSIS		**ICD 10**

STEP 1: TYPE OF TRAINING *(Check all that apply and/or specify under Step 2 Special Instructions.)*

☐ **Comprehensive Diabetes Education** (10 hours or _______)
Education provided in a group unless special needs apply.

☐ **Continuous Glucose Monitoring**
Education and training for:
- ☐ Personal use
- ☐ Professional use (seven-day blood glucose evaluation)

☐ **Diabetes Prevention Program** (26 visits)
Follows CDC curriculum

☐ **Medical Nutrition Therapy** (2 hours or _______)
Nutrition-focused education

☐ **Other education** *(please specify)*:

Diabetes Education During Pregnancy

EDD: ____

Specify: ☐ Type 1 ☐ Type 2 ☐ Gestational Diabetes

Insulin & Injectables

** All prescriptions must be submitted by referring provider.**

☐ **Initiate insulin as directed below:**
Type:
Dose:
Timing:
Administration mode: Pen Vial
Continue oral meds: Yes No
Titration follow-up plan:

☐ **Initiate and titrate insulin according to Providence protocol:**
Type:
Administration mode: Pen Vial
Continue oral meds: Yes No

☐ **Other injectable:**
Type:
Dose:
Timing:
Titration follow-up plan:

STEP 2: SPECIAL INSTRUCTIONS

STEP 3: SPECIAL NEEDS *(Check all that apply.)*

☐ Vision/Hearing ☐ Impaired mobility or dexterity ☐ Impaired mental status ☐ Learning disability

☐ Interpreter needed/Language: ____________________________ ☐ Other: ____________________________

STEP 4: CURRENT CLINICAL DATA *Specify or attach lab report and medication list.*

Date of lab values: _______/_______/_______

HbA_1c ________________ Fasting BG ________

Random BG ___________

OGTT 1hr______ 2hr______ 3hr______

Diabetes and other pertinent medications/dose: ____________________________

____

____

STEP 5: SIGN BELOW AND FAX THIS FORM. *Please see reverse side for clinic locations.*

By signing this form, I certify that I am managing the patient's diabetes and the training described is needed to ensure therapy compliance or to provide the beneficiary with the skills and knowledge to help manage their diabetes.

Physician Signature ____ Date _________________________

Columbia Gorge/Hood River
Fax: 541-387-6142

Portland Metro/Oregon City/Newberg
Fax: 503-215-6240

Medford/Central Point
Fax: 541-732-6959

Providence Diabetes Health & Wellness Education
Oregon Locations

For more information, visit: **www.providence.org/diabetes**

Columbia Gorge/Hood River	Medford/Central Point
Fax: 541-387-6142	**Fax: 541-732-6959**

Providence Hood River Memorial Hospital
1151 May Street
Hood River, OR 97031
Phone: 541-387-6381

Providence Medford
698 E McAndrews, Ste 220
Medford, OR 97504
Phone: 541-732-6955

Portland Metro/Oregon City/Newberg
Fax: 503-215-6240

Providence Newberg Medical Center
1001 Providence Drive
Newberg, OR, 97132
Phone: 503-215-6628

Providence Portland Medical Center
5211 NE Glisan, Bldg C
Portland, OR 97213
Phone: 503-215-6628

Providence St Vincent Medical Center
9340 SW Barnes, Ste 200
Portland, OR 97224
Phone: 503-215-6628

Providence Willamette Falls Medical Center
1511 Division Street, Ste 201B
Oregon City, OR 97045
Phone: 503-215-6628

Medicare requires that referrals for diabetes education contain:

1. Demographics: Patient name and contact info
2. Diagnosis: ICD 10 code
3. Type of education requested
4. Special needs: language, vision, hearing, mobility, etc.
5. Medication list and recent labs
6. Referring provider signature