Diabetes Self-Management Education and Support Referral Form

Date: _____

Patient's Name: _____ Social Security Number: _____

DOB: _____ Gender: M ___ F ___

Patient's Address: _____

Phone Number: _____ Insurance: Yes ____ No ____

***Please include copy of patient's insurance card(s) (front and back)**

Diabetes Diagnosis:

❑ Type 1 ❑ Gestational

❑ Type 2 Diagnosis Code _____

Initial HbA1c: _____ Fasting Blood Glucose: _____

*** Please send office notes and recent labs for patient eligibility and outcomes monitoring**

Referral For:

❑ Initial Comprehensive Diabetes Self-Management Education (DSMES) ❑ DSMES: Follow-up

Specific Topics: _____

*DSME can be ordered by an MD, DO or midlevel provider managing the patient's diabetes.

Indicate any barriers to group learning or additional insulin training requiring 1:1 education:

❑ Impaired Mobility ❑ Impaired Vision ❑ Impaired Hearing ❑ Impaired Dexterity

❑ Impaired Mental Status Recognition ❑ Language Barrier ❑ Eating Disorder

❑ Learning Disability or Other (Please Specify): _____

❑ 1:1 Insulin Training

Clinician's Printed Name: _____

Clinician's Signature: _____ Date: _____

Group Practice Name: _____

Address: _____

Group Practice
Phone/Fax Numbers: _____

Please fax all referrals to:
Mississippi State Department of Health
Diabetes Prevention and Control Program
Fax Number: 601-899-0154
Attention: Diabetes Program

Diabetes Self Management Education Referral Form
Form 52E

PURPOSE
The purpose of this form is to provide a method of referral for healthcare providers of clients diagnosed with diabetes to be enrolled in the Mississippi State Department of Health (MSDH) Diabetes Self-Management Education Support (DSMES) Program.

INSTRUCTIONS
This form is to be completed on all clients referred to the MSDH DSMES Program.

This form is to be completed by the referring provider. (*DSMES can be ordered by an MD, DO or midlevel provider managing the patient's diabetes.

Diabetes Self-Management Education and Support Referral Form

Date – Enter today's date.

Patient's name – Enter client's first and last name.

Patient's social security number – Enter the client's social security number.

DOB – Enter client's date of birth.

Gender – Check M for male or F for female.

Patient's Address – Enter name of street and number where client lives. Enter P.O. Box as well if applicable.

City/State/Zip Code - Enter city, state, and zip code where patient lives.

Phone number(s) – Enter phone number(s) where client can be reached.

Insurance – Check yes if client has insurance, if not check no.

Insurance card – Attach copy of client's insurance card, both front and back.

Diabetes Diagnosis – Check the box that applies to the type of diabetes the client has been diagnosed with.

Initial HbA1c – Enter the current HbA1c value as indicated on the client's lab report.

Fasting Blood Glucose – Enter the current fasting blood glucose value as indicated on the client's lab report.

Diagnosis Code – Enter the diagnosis code that corresponds with the client's diabetes diagnosis

Referral For – Check all that apply.

Specific Topics – Enter specific topics to be covered if applicable.

Indicate any barriers to group learning or additional insulin training requiring 1:1 education – check all that apply

Clinician's printed name and signature – Enter printed name and signature of referring physician/provider

Group Practice – Enter name of group practice of referring physician/provider

Group Practice Address – Enter address of group practice of referring physician/provider

Group Practice Phone/Fax number – Enter phone/fax numbers of group practice of referring physician/provider