New Hanover County
Health Department
2029 South 17th Street
Wilmington, NC 28401-4946

Your Health Our Priority
NEW HANOVER COUNTY HEALTH DEPARTMENT

Patient's name_____ **SS#** _____ **Health Insurance**_____

DOB: _____ **Phone #** _____**Today's Date:** _____

Race: _____

Diabetes Diagnosis:
ICD-10_____

Current Treatment
☐ Diet and Exercise ☐Oral Agents: _____ ☐ Insulin _____

Indicate one or more reason for referral:
☐ Recurrent elevated blood glucose levels
☐ Recurrent hypoglycemia
☐ Change in DM treatment regimen
☐ High risk due to diabetes complications/co-morbid conditions:
☐Retinopathy ☐Neuropathy ☐Nephropathy ☐Gastroparesis ☐Hyperlipidemia
☐Hypertension ☐Cardiovascular disease ☐Other _____

Height _____ **Weight** _____ **Blood Pressure** _____

Recent Labs:
FBG _____ Date: _____
Hgb A1C _____ Date: _____
Micro-albumin _____ Date: _____
Total Cholesterol_____ Date: _____
HDL _____ Date: _____
LDL _____ Date: _____
Triglycerides: _____ Date: _____

Please include last notes and labs:

Education needed
☒ Comprehensive Self Management Skills (group)
☐Insulin Instruction
☐Medical Nutrition Therapy (MNT) ☐Self blood glucose monitoring
☐Management of Diabetes during Pregnancy/Gestational Diabetes Education

Indicate any existing barriers requiring customized education:
☐Impaired mobility ☐Impaired vision ☐Impaired hearing ☐Impaired dexterity
☐Language barrier ☐Impaired mental state/cognition ☐Eating disorder
☐Learning disability (please specify):_____
☐Other (please specify): _____

I hereby certify that I am managing this beneficiary's diabetes condition and that the above prescribed training is a necessary part of management. (Medicare patients)

Provider's Signature: (Required) _____

Provider's Name: (Printed) _____

Referring Facility _____**Telephone** _____

Fax Referral Form to: 910-772-7805
Questions call Diabetes Line, 910-798-6775