

**DIABETES HEALTHSOURCE**  
 2400 Clinton Crossings, Suite 135, Bldg. H  
 Rochester, NY 14618  
 Phone: 585.341.7066  
 Fax: 585.341.7945



**ORDER/REFERRAL FORM**

Please fax to: 585.341.7945

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Insurance \_\_\_\_\_ Phone \_\_\_\_\_  
 Referral #: \_\_\_\_\_ Interpreter/Language \_\_\_\_\_  
 Special Needs:  Vision  Hearing  Physical  Cognitive Impairment  
 Physician Name/Practice \_\_\_\_\_  
 Physician Signature (REQUIRED) \_\_\_\_\_ Date \_\_\_\_\_

**RECENT LAB DATA or ATTACH COPY**

Date \_\_\_\_\_  
 Cholesterol \_\_\_\_\_ HDL \_\_\_\_\_ LDL \_\_\_\_\_  
 FBS \_\_\_\_\_ Triglyceride \_\_\_\_\_ HgbA1C \_\_\_\_\_

**PREGNANCY DATA or ATTACH COPY**

Date \_\_\_\_\_ ( 1 hr screen) \_\_\_\_\_  
 Date \_\_\_\_\_ ( 3 hr GTT ) FBS \_\_\_\_\_ 1 hr \_\_\_\_\_ 2 hr \_\_\_\_\_ 3 hr. \_\_\_\_\_

**REASON FOR REFERRAL** (please check all that apply):

**Diabetes Self-Management Training** (must have diagnosis of diabetes or renal disease)  
 New DM Referral  Follow-Up DM Referral  
 **Medical Nutrition Therapy**  
 **Continuous Monitoring** (3 day blood glucose monitor)  
 Diabetes  Overweight/Obesity  
 Type 1  Type 2  Pre-diabetes  High Cholesterol  
 Pregnancy - Due Date \_\_\_\_\_  High Triglycerides  
 Gestational DM  Pre-existing  HTN  
 Type 1  Type 2  Metabolic Syndrome  
 Insulin Administration  Gastrointestinal Disorder, type \_\_\_\_\_  
 Insulin Type(s) \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_  Chronic Kidney Disease, stage \_\_\_\_\_  
 Insulin Type(s) \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_  Other: \_\_\_\_\_  
 Other Injectable Medication: \_\_\_\_\_

**Group Education Classes**

Living with Diabetes Series  Diabetes Wake-Up Call (pre-DM)\*  Healthy Nutrition Series\*

\* not covered by insurance (\$10/class)

\*\*\*REFERRALS MUST BE RENEWED ANNUALLY FOR MNT AND FOLLOW UP DSMT\*\*\*