Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City & ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all that apply and fax with physician’s signature.**

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| --- | --- | --- |
| **Diagnosis: Medical Status:**  ❒ Type 1 ❒ Newly Diagnosed  ❒ Type 2 ❒ New to Insulin  ❒ Pre-diabetes ❒ New to Oral anti-diabetes med.  ❒ Gestational ❒ Severe Hypo-Hyperglycemia requiring ED visits or hospitalization  ❒ HbA1c ≥ 8.5, 2 consecutive times 3 or more months apart  ❒ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Complications** ❒ N/A  ❒ frequent hypoglycemia ❒ nephropathy  ❒ retinopathy ❒ neuropathy  ❒ vascular disease  ❒ foot ulcer, charcot |
| **Classes:** ❒ Gestational Diabetes Class | | |
| **Diet:**  ❒ Per Dietitian/CDE Recommendations  ❒ Sodium Restriction  ❒ Fluid Restriction  ❒ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Exercise:**  ❒ May participate in 30 min. walking/stretching  ❒ May participate in stretching as tolerated  ❒ May not participate | |
| **For Insulin Start (only):**  ❒ OK to instruct patient on insulin self-management.  ❒ Insulin (type, dose, frequency): ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Recent Results:**  Pregravid weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of previous pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_  GTT—Blood Glucose Levels: FBS \_\_\_\_\_\_\_\_\_\_ 1 Hr. \_\_\_\_\_\_\_\_ 2 Hr. \_\_\_\_\_\_\_\_\_ 3 Hr. \_\_\_\_\_\_\_\_\_\_  Date GTT Obtained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Referring Physician** *(print)***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Physician Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |