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TakeCare
A TanHoldings Company

Diabetes Self-Management Education and Support (DSMES) Program Referral Form

Full Name: _____
First Name MI Last Name

DOB:_____ Gender: ☐ Male ☐ Female ☐ Other(s): _____

Home Phone#:_____ Cell Phone#:_____

Referring Provider/Primary Care Physician: _____ Clinic: _____

Diabetes Diagnosis:

☐ Type 1 ☐ Type 2 ☐ Pre-diabetes
☐ Gestational ☐ Pre-Existing DM with Pregnancy ☐ Others: _____

Referral For:

☐ Initial Comprehensive Diabetes Self-Management Education and Support/Training (DSMES/T) – all 9 topics (Diabetes disease process, Nutrition, Physical activity, BG monitoring, Medication, Acute complications, Chronic complications, Psychosocial concerns, and Health/Behavior change)
☐ DSMES/T: Follow-up
☐ Specific Topics and Hours if needs vary from above: _____

- ☐ Pathophysiology of diabetes and treatment options
- ☐ Reducing risks (treating acute and chronic complications
- ☐ Healthy coping
- ☐ Healthy eating
- ☐ Monitoring, including CGM
- ☐ Preconception, pregnancy, GDM
- ☐ Problem solving and behavior change strategies
- ☐ Being active
- ☐ Taking medication, including Insulin and/or injection training

Indicate any barriers to group learning or additional insulin training requiring _____ hours of 1:1 training:

☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing
☐ Impaired dexterity ☐ Impaired mental status/cognition ☐ Language barrier
☐ 1:1 Insulin Training ☐ No group sessions available within 2 months
☐ Learning disability or 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.

Physician's/ Provider's Signature: _____ Date:_____

Physician's/ Provider's NPI:_____