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| **PATIENT INFORMATION** | | | | |
| **Last name**: | | **First:** | | **Middle Initial:** |
| **Phone(Home): Phone(Cell): Phone(Alternate):** | | | | |
| **Date of Birth:** | **Sex: M F** | | **City: State:** | |
| **Caregiver Name:** | **Relationship to Pt**: | | | **Phone #:** |
| **Date of Patient’s Next Appointment:** | **Primary Care Provider:** | | | |
| **REASON FOR CONSULTATION** | | | | |

The patient is being referred to a KCMPA Dietitian or Diabetes Educator for the following reason(s):

**Comprehensive Diabetes Education** *(group or individual)*

Appropriate for patients with Newly Diagnosed Diabetes or No Previous/Recent Diabetes Education

***Include Recent Clinical Note (Hospital Discharge or Visit Summary), Medication List, A1C***

**Problem-Oriented Diabetes Education** *(individual)*

Appropriate for patients who need personalized attention *(please indicate reason below)*:

Uncontrolled diabetes (ex. -- A1C greater than 9, frequent hypoglycemia)

Non-adherence to diabetes treatment plan

Review of diabetes medication/insulin regimen *(attach insulin titration protocol, if available)*

Post discharge diabetes education *(include discharge summary, if available)*

Patient with special needs -- Vision Hearing Cognitive Language Other:\_\_\_\_\_\_\_\_\_\_\_\_

Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Include Recent Clinical Note (Hospital Discharge or Visit Summary), Medication List, A1C, Relevant Labs***

* **Unable to afford diabetes medication/supplies**

**Other** (please specify reason for referral) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any additional details related consultation request below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FOLLOW-UP INFORMATION** |

**Important:**

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| **Name of person making referral:**  **Practice contact (If different than person making referral):** |
| **Preferred follow-up: Phone: Ext: Fax:** |
| **Summary of findings, following encounter with KCMPA diabetes educator, will be emailed\* to the designated email addresses:** |

Email completed form and supporting materials to haley.nagel@kcmetrophysicians.com or fax to 816.388.9369

\*Only utilize email communication if encrypted email is available, to ensure patient privacy & PHI security