



Diabetes Self Management Education Program (DSMEP) at Downstate
Referral Form

Patient Information	
Name _____ DOB _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	
Phone (H) _____ Phone (C) _____ Phone (W) _____	
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> French <input type="checkbox"/> Russian <input type="checkbox"/> Other _____	
Diabetes Diagnosis	
<input type="checkbox"/> Pre DM <input type="checkbox"/> DM Type 2 Diet <input type="checkbox"/> DM Type 2 Oral <input type="checkbox"/> DM Type 2 Insulin <input type="checkbox"/> DM Type 2 Oral + Insulin	<input type="checkbox"/> DM Type 1 <input type="checkbox"/> Pre-existing DM with Pregnancy <input type="checkbox"/> Gestational <input type="checkbox"/> DM Post Transplant <input type="checkbox"/> Other _____
<p style="text-align: center;"><u>Diabetes Complications</u> <u>(Circle all that apply)</u></p> <p>Hypertension Non-healing wound</p> <p>Mental/affective disorder Neuropathy</p> <p>PVD Retinopathy Stroke</p> <p>CHD Nephropathy CAD</p> <p>Gastroparesis Hyperlipidemia</p> <p>Obesity Other: _____</p>	<p><u>Diabetes Self-Management Training (DSMT) Medicare</u> (10 hours initial DSMT in 12 month period, plus 2 hours f/u DSMT annually) Choose all that apply:</p> <input type="checkbox"/> Initial DSMT Class (10 hours) <input type="checkbox"/> Follow-up DSMT Reason _____ <input type="checkbox"/> Additional MNT (services in the same calendar year, specify change in medical condition, treatment or diagnosis: _____)
<p>Patients with special needs requiring individual DSMT Check all special needs that apply:</p> <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Physical <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Language <input type="checkbox"/> Other _____	<p><u>Reasons for DSME Referral:</u></p> <input type="checkbox"/> Newly diagnosed <input type="checkbox"/> Recurrent elevated BG levels <input type="checkbox"/> Recurrent/frequent hypoglycemia <input type="checkbox"/> HbA1c > _____ <input type="checkbox"/> Abnormal OGT <input type="checkbox"/> Recent admission DKA/HHNS <input type="checkbox"/> Frequent utilization of ED <input type="checkbox"/> Other: _____
<p><u>Exercise Instructions:</u></p> <input type="checkbox"/> There are no contraindications toward participants in a fitness program. <input type="checkbox"/> I believe the patient can participate _____ <input type="checkbox"/> The applicant should not engage in the following activities: _____ <input type="checkbox"/> Other _____	<p><u>Lab/Measurements:</u></p> HbA1c _____ Date _____ Blood Pressure _____ Date _____ Microalbumin _____ Date _____ Lipids _____ Date _____ Weight _____ Height _____ Date _____
<u>Current Medications:</u>	
Physician Name (print/stamp)	Signature _____ Date: _____
UPIN # _____ License# _____	Phone # _____



SUNY
DOWNSTATE
Medical Center

University Hospital of Brooklyn

DATE:

DIABETES SELF MANAGEMENT EDUCATION PROGRAM

To Patient

Call the Appointment Call Center at 718-270-7207 to make an appointment to attend the Diabetes Self Management Education Class.